

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5729

CERTIFICATE OF DEATH

Reg. Dist. No.

05704

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
c. LENGTH OF STAY IN 1b <b>5 days</b>				d. STREET ADDRESS <b>14141 Layhill Rd.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Palmer</b> Middle <b>Eddy</b> Last <b>Allen</b>				4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4.1.88</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>59</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Policeman</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Palmer A. Allen</b>		14. MOTHER'S MAIDEN NAME <b>Callie Summers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Hospital Records,</b>			
17. INFORMANT <b>Hospital Records,</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis Aorta</b> DUE TO (c) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b> <b>8 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/30</b> , 19 <b>59</b> , to <b>5/5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/4/59</b> , 19 <b>59</b> , and that death occurred at <b>8:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. W. Bird, M. D.</b>				ADDRESS (Street, city or town, state) <b>Sandy Spring, Md.</b>			
PHYSICIAN'S NAME (Type) <b>J. W. Bird, M. D.</b>				DATE SIGNED <b>5/5/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>May 7-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sanitand Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Summers Brothers</b>				ADDRESS <b>1661-94 Hope</b>			
24a. REC'D BY REGISTRAR <b>DATE MAY 6 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18, Parts MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

I & II

7/6/59 RS Film # C 244

# CERTIFICATE OF DEATH

05705

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>2 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>3636 16th St., N.W. - Apt. B633</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Herman</b> Last <b>ARONSON</b>			4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>19 59</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-66</b>		9. AGE (In years last birthday) <b>93</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>		11. BIRTHPLACE (State or foreign country) <b>Sweden</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>(D) Miss Alice H. Aronson, same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis, Acute, generalized</b> <b>153.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma, ascending colon with perforation</b> (c) <b>Myocardial infarction; Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial infarction; Arteriosclerotic Heart Disease</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>May 10</b> , 19 <b>59</b> , to <b>May 12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 11</b> , 19 <b>59</b> , and that death occurred at <b>12:50A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NMMC</b> DATE SIGNED <b>5-12-59</b> ACTUAL SIGNATURE <b>M. C. Shea</b> M.D. PHYSICIAN'S NAME (Type) <b>M. C. SHEA, Lieutenant, MC, USN Bethesda, Maryland</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b> 22b. DATE THEREOF <b>5-13-59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Fairmount Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Denver Colorado</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Fairmount Funeral Home, Bethesda, Md.</b> ADDRESS <b>4444</b> 24a. REC'D BY REGISTRAR <b>MAY 14 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1910

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan. Some visible text includes "Name of Deceased", "Date of Death", and "Place of Death".



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5731 CERTIFICATE OF DEATH

Reg. Dist. No. 05706

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2600 ELMONT ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>WHEATON-</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HATTIE ESTELLE AUBINOE</u>				4. DATE OF DEATH Month Day Year <u>MAY 21 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/3/190</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WILLIAM. E. RANDALL</u>				14. MOTHER'S MAIDEN NAME <u>MAY DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>Mr. Harry S. Aubinoe, 2600 Elmont St. Wheaton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden Occlusion of the Artery</u> DUE TO (c) <u>at circumflex coronary artery</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 19, 1959</u> to <u>May 21, 1959</u> , that I last saw the deceased alive on <u>May 21, 1959</u> , and that death occurred at <u>2:38</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>George A. Granger</u> M.D.				104 Cherry Chase Rd. St. 1/5			
PHYSICIAN'S NAME (Type) <u>George A. GRANGER</u>				<u>R.N.D. Cherry Chase Rd. St. 1/5</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. DUMTHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

43524

ST-310MP163-114517

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## 5710 CERTIFICATE OF DEATH

Reg. Dist. No.

05707

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SAN. &amp; HOSPITAL</b>		1 d. STREET ADDRESS <b>12,022 BLUHILL ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>ANDREW</b> Last <b>Austin</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/18/24</b>
9. AGE (In years, last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OWNER OF MARKET</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARKET</b>	
11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES R. AUSTIN</b>		14. MOTHER'S MAIDEN NAME <b>CINNIE WAGES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>243-24-7194</b>	
17. INFORMANT <b>Mrs. Ramona H. Austin, 12,022 Bluhill Road, Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia.</b> 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Pancreatitis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 5/24/59</b> , 19 <b>58</b> , to <b>5/24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/24/59</b> , 19 <b>59</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles M. Weber</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>12600 Parklawn Drive Rockville Md</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES M. WEBER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/27/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WERNER E. PUMPHREY, INC.</b> <b>Raymond A. Glick</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2010 CERTIFICATE OF DEATH

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1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. MANNER OF DEATH [Faint text]		10. SIGNATURE OF PHYSICIAN [Faint text]	
11. SIGNATURE OF REGISTRAR [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. SIGNATURE OF DECEASED [Faint text]		14. SIGNATURE OF NEXT OF KIN [Faint text]	
15. SIGNATURE OF CLERK [Faint text]		16. SIGNATURE OF JURY [Faint text]	
17. SIGNATURE OF JUDGE [Faint text]		18. SIGNATURE OF SHERIFF [Faint text]	
19. SIGNATURE OF CORONER [Faint text]		20. SIGNATURE OF DISTRICT ATTORNEY [Faint text]	
21. SIGNATURE OF COUNTY CLERK [Faint text]		22. SIGNATURE OF CITY CLERK [Faint text]	
23. SIGNATURE OF TOWNSHIP CLERK [Faint text]		24. SIGNATURE OF VILLAGE CLERK [Faint text]	
25. SIGNATURE OF POST OFFICE CLERK [Faint text]		26. SIGNATURE OF SCHOOL CLERK [Faint text]	
27. SIGNATURE OF CHURCH CLERK [Faint text]		28. SIGNATURE OF SYNAGOGUE CLERK [Faint text]	
29. SIGNATURE OF MOSQUE CLERK [Faint text]		30. SIGNATURE OF TEMPLE CLERK [Faint text]	
31. SIGNATURE OF OTHER CLERK [Faint text]		32. SIGNATURE OF OTHER CLERK [Faint text]	
33. SIGNATURE OF OTHER CLERK [Faint text]		34. SIGNATURE OF OTHER CLERK [Faint text]	
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49. SIGNATURE OF OTHER CLERK [Faint text]		50. SIGNATURE OF OTHER CLERK [Faint text]	
51. SIGNATURE OF OTHER CLERK [Faint text]		52. SIGNATURE OF OTHER CLERK [Faint text]	
53. SIGNATURE OF OTHER CLERK [Faint text]		54. SIGNATURE OF OTHER CLERK [Faint text]	
55. SIGNATURE OF OTHER CLERK [Faint text]		56. SIGNATURE OF OTHER CLERK [Faint text]	
57. SIGNATURE OF OTHER CLERK [Faint text]		58. SIGNATURE OF OTHER CLERK [Faint text]	
59. SIGNATURE OF OTHER CLERK [Faint text]		60. SIGNATURE OF OTHER CLERK [Faint text]	
61. SIGNATURE OF OTHER CLERK [Faint text]		62. SIGNATURE OF OTHER CLERK [Faint text]	
63. SIGNATURE OF OTHER CLERK [Faint text]		64. SIGNATURE OF OTHER CLERK [Faint text]	
65. SIGNATURE OF OTHER CLERK [Faint text]		66. SIGNATURE OF OTHER CLERK [Faint text]	
67. SIGNATURE OF OTHER CLERK [Faint text]		68. SIGNATURE OF OTHER CLERK [Faint text]	
69. SIGNATURE OF OTHER CLERK [Faint text]		70. SIGNATURE OF OTHER CLERK [Faint text]	
71. SIGNATURE OF OTHER CLERK [Faint text]		72. SIGNATURE OF OTHER CLERK [Faint text]	
73. SIGNATURE OF OTHER CLERK [Faint text]		74. SIGNATURE OF OTHER CLERK [Faint text]	
75. SIGNATURE OF OTHER CLERK [Faint text]		76. SIGNATURE OF OTHER CLERK [Faint text]	
77. SIGNATURE OF OTHER CLERK [Faint text]		78. SIGNATURE OF OTHER CLERK [Faint text]	
79. SIGNATURE OF OTHER CLERK [Faint text]		80. SIGNATURE OF OTHER CLERK [Faint text]	
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83. SIGNATURE OF OTHER CLERK [Faint text]		84. SIGNATURE OF OTHER CLERK [Faint text]	
85. SIGNATURE OF OTHER CLERK [Faint text]		86. SIGNATURE OF OTHER CLERK [Faint text]	
87. SIGNATURE OF OTHER CLERK [Faint text]		88. SIGNATURE OF OTHER CLERK [Faint text]	
89. SIGNATURE OF OTHER CLERK [Faint text]		90. SIGNATURE OF OTHER CLERK [Faint text]	
91. SIGNATURE OF OTHER CLERK [Faint text]		92. SIGNATURE OF OTHER CLERK [Faint text]	
93. SIGNATURE OF OTHER CLERK [Faint text]		94. SIGNATURE OF OTHER CLERK [Faint text]	
95. SIGNATURE OF OTHER CLERK [Faint text]		96. SIGNATURE OF OTHER CLERK [Faint text]	
97. SIGNATURE OF OTHER CLERK [Faint text]		98. SIGNATURE OF OTHER CLERK [Faint text]	
99. SIGNATURE OF OTHER CLERK [Faint text]		100. SIGNATURE OF OTHER CLERK [Faint text]	





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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 5/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

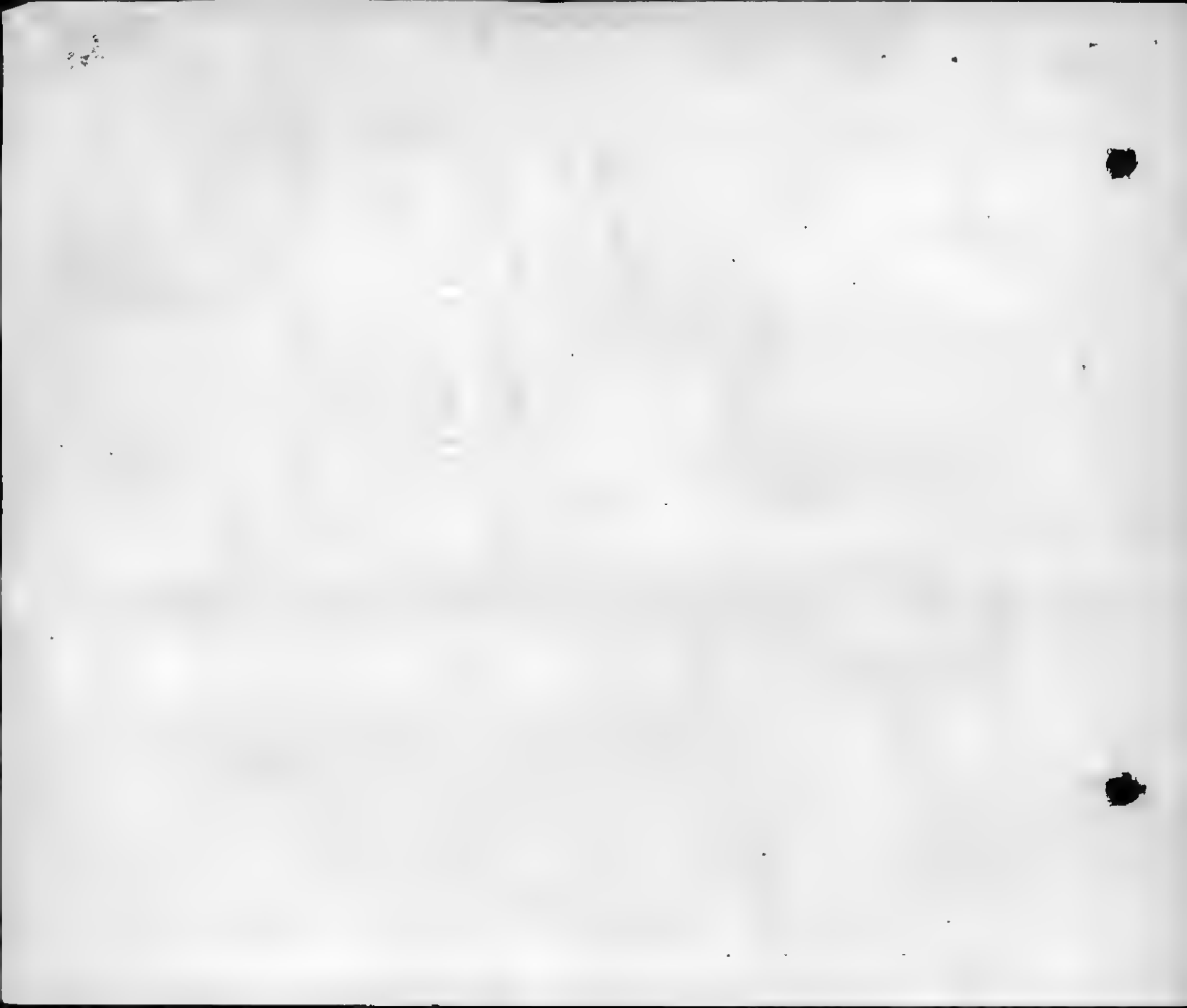
5733

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05709

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Germany</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Weilheim</u>	
c. LENGTH OF STAY IN 1b <u>19 days</u>		d. STREET ADDRESS <u>8 Markt Platz</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12921 Maty Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Eugen <del>W. B. B.</del> Banerle</u>		4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist (Dental Surgeon)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own business</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u> ✓	
13. FATHER'S NAME <u>Wilhelm Banerle</u>		14. MOTHER'S MAIDEN NAME <u>MARIA BAUR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Helma A. Barker - daughter - Item 1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			
4-10-1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		22b. DATE THEREOF <u>5/25/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GERMAN WAR VETERANS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CHICAGO, ILLINOIS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		24a. REC'D BY REGISTRAR <u>Arthur E. Hanna</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		DATE <u>MAY 26 '59</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

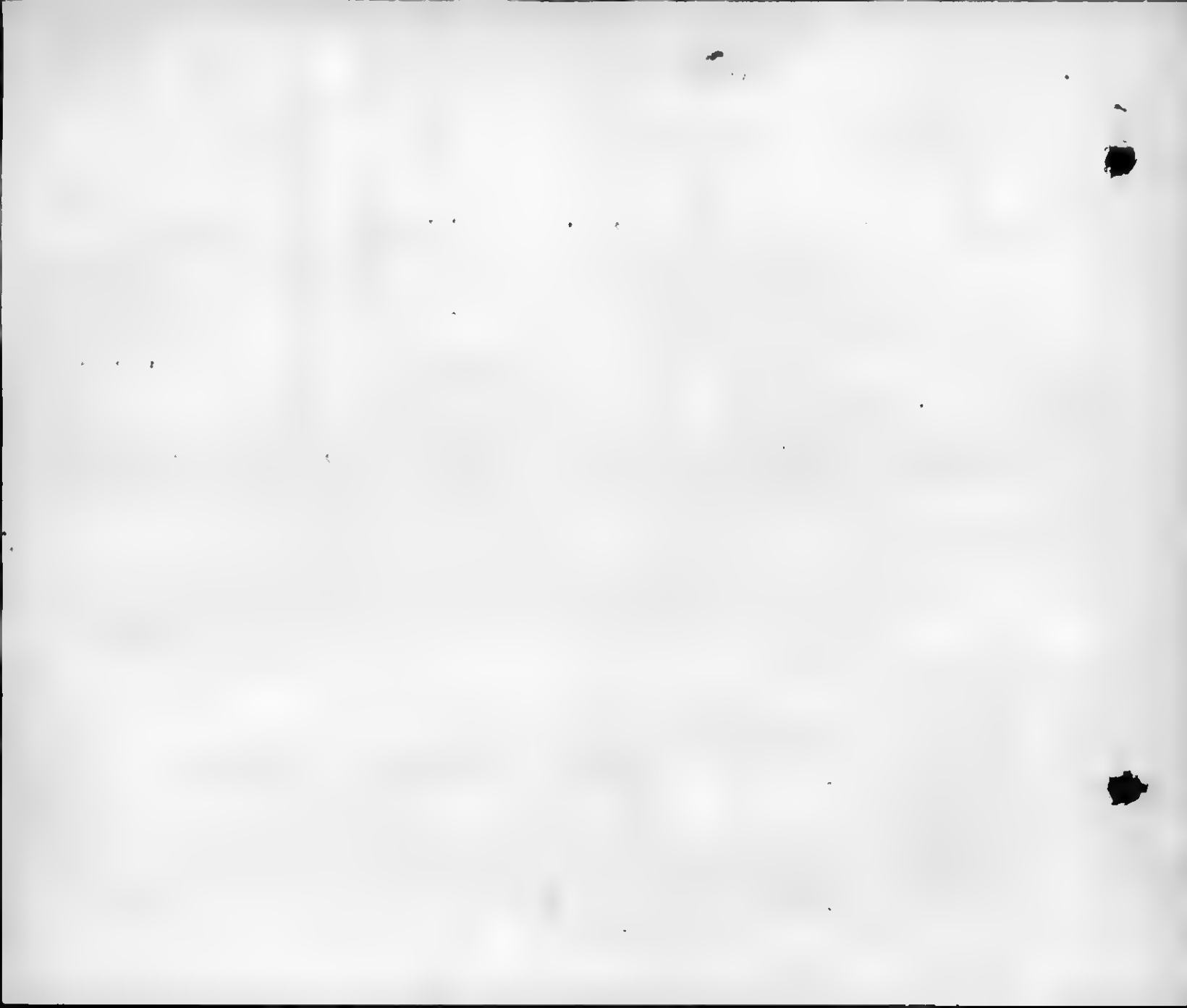
5734 CERTIFICATE OF DEATH

Reg. Dist. No.

05710

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Florida</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atlantic Beach</u> 41	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			d. STREET ADDRESS <u>P.O. Box 1782</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Page</u> Last <u>Borden</u>			4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>19 59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1911</u>		9. AGE (In years last birthday) <u>48</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>	
13. FATHER'S NAME <u>John C. Borden</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unascertainable</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Heart Disease with mitral stenosis</u> DUE TO <u>and mitral insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe emphysema</u> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 3, 19 59</u> , to <u>May 25, 19 59</u> , that I last saw the deceased alive on <u>May 25, 19 59</u> , and that death occurred at <u>10:02 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>William P. Cornell</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u>		DATE SIGNED <u>5-25-59</u>	
PHYSICIAN'S NAME (Type) <u>William P. Cornell, M.D.</u>		National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, or other final disposition <u>Trans Burial</u>		22b. DATE THEREOF <u>5/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Jacksonville Florida</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A Pumphrey</u>			24a. RECEIVED BY REGISTRAR <u>MAY 28 1959</u>		
Address <u>Bethesda</u>			24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5711

## CERTIFICATE OF DEATH

Reg. Dist. No.

05711

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14th Ave Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Victoria Elizabeth Boschet</u>		4. DATE OF DEATH <u>May 3 1959</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-15</u>
9. AGE (In years, last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Mac Galliard</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Cone</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Record</u>	
17. INFORMANT <u>Hospital Record</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Post Hemorrhagic hypotensive coma</u> DUE TO <u>Cirrhosis of the liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>approx 10 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>  </u>		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u>  </u> p. m. <u>  </u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>		21. I certify that I attended the deceased from <u>4/30</u> , 19 <u>59</u> , to <u>5/3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/2</u> , 19 <u>59</u> , and that death occurred at <u>5:25 AM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Wayne Glickfield</u>		ADDRESS (Street, city or town, state) <u>6826 Piggott, Hyattsville, Md</u>	
PHYSICIAN'S NAME (Type) <u>H. WAYNE GLICKFIELD, M.D.</u>		DATE SIGNED <u>5/3/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>5/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Portsmouth, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hume Co. 2901-14</u>		ADDRESS <u>  </u>	
24a. REC'D BY REGISTRAR <u>MAY 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krause</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5735

## CERTIFICATE OF DEATH

05712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution residence before admittance) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Drury</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Montgomery Co. Gen. Hspital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Clara Jane Bowman</i>		4. DATE OF DEATH <i>May - 2 - 1959</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec-12-1879</i>
9. AGE (In years last birthday) <i>79</i>		10. IF UNDER 1 YEAR: Months <i>4</i> Days <i>28</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>domestic nursing</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>nursing</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Columbus Crawford</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jane Hella Ray</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i> (If yes, give war or dates of service) <i></i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Eleanor King</i>		Address <i>R-2-Boyd, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary - congestive failure</i> DUE TO <i>Diabetes</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>few hours</i> <i>5-10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21. I certify that I attended the deceased from <i>April - 14 - 1959</i> to <i>May - 2 - 1959</i> , that I last saw the deceased alive on <i>May - 1 - 1959</i> , and that death occurred at <i>8:20 A.M.</i> from the cause and on the date stated above			
ACTUAL SIGNATURE <i>William C. Miller</i>		ADDRESS (Street, city or town, state) <i>7-Brooks Ave.</i>	
PHYSICIAN'S NAME (Type) <i>William C. Miller</i>		DATE SIGNED <i>Griffithsburg, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-5-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Upper Seneca Baptist Ch</i>	22d. LOCATION (City, town, or county) (State) <i>Cedar Grove Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest C. Fecton</i>		ADDRESS <i>Griffithsburg, Md</i>	
24a. REC'D BY REGISTRAR <i></i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	
DATE <i>MAY 6 '59</i>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PC PP31-21 314

1999

1919

1950-1951

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1945-1946

2000 10/10/00

1940

11/11/11

5736

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 hrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						d. STREET ADDRESS Rt. #3, Box 338				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Randolph N.			First Middle Last BOWMAN			4. DATE OF DEATH Month Day Year May 1 19 59					
5 SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-29-59		9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George R. BOWMAN						14. MOTHER'S MAIDEN NAME Jeanette V. BLOMQUIST					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 1-4-5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital Disease</u> DUE TO (c) <u>3 days</u>										INTERVAL BETWEEN ONSET AND DEATH immed.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>May 1</u> 19 <u>59</u> , to <u>May 1</u> 19 <u>59</u> , that I last saw the deceased alive on <u>May 1</u> 19 <u>59</u> , and that death occurred at <u>5:45P</u> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>David Harris</u>						ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC			DATE SIGNED 5-2-59		
PHYSICIAN'S NAME (Type) David HARRIS, LT, MC, USN						Bethesda 14, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-4-59		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) Glen Burnie Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton Funeral Home</u>						ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE MAY 6 '59		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 5737 CERTIFICATE OF DEATH

05714

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>59 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> d. STREET ADDRESS <b>7220 Everglades Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Emma Elizabeth BRADFORD</b>		4. DATE OF DEATH Month Day Year <b>May 11 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-14-05</b>
9. AGE (In years last birthday) <b>53</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Radcliff</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Stevenson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Squamous cell carcinoma, uterus</b> DUE TO (c) <b>Adenocarcinoma, colon</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b> <b>3 yrs</b> <b>4 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 13</b> , 19 <b>59</b> , to <b>May 11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 11</b> , 19 <b>59</b> , and that death occurred at <b>3:00P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>C. M. Garland, Jr.</b> M.D. <b>U. S. Naval Hospital, NNMC</b> <b>5-12-59</b>			
ACTUAL SIGNATURE <b>C. M. Garland, Jr.</b>			
PHYSICIAN'S NAME (Type) <b>C. M. GARLAND, JR., CDR, MC, USN Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-15-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers, 1400 Chapin St., N.W., Wash.DC</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 14 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5738

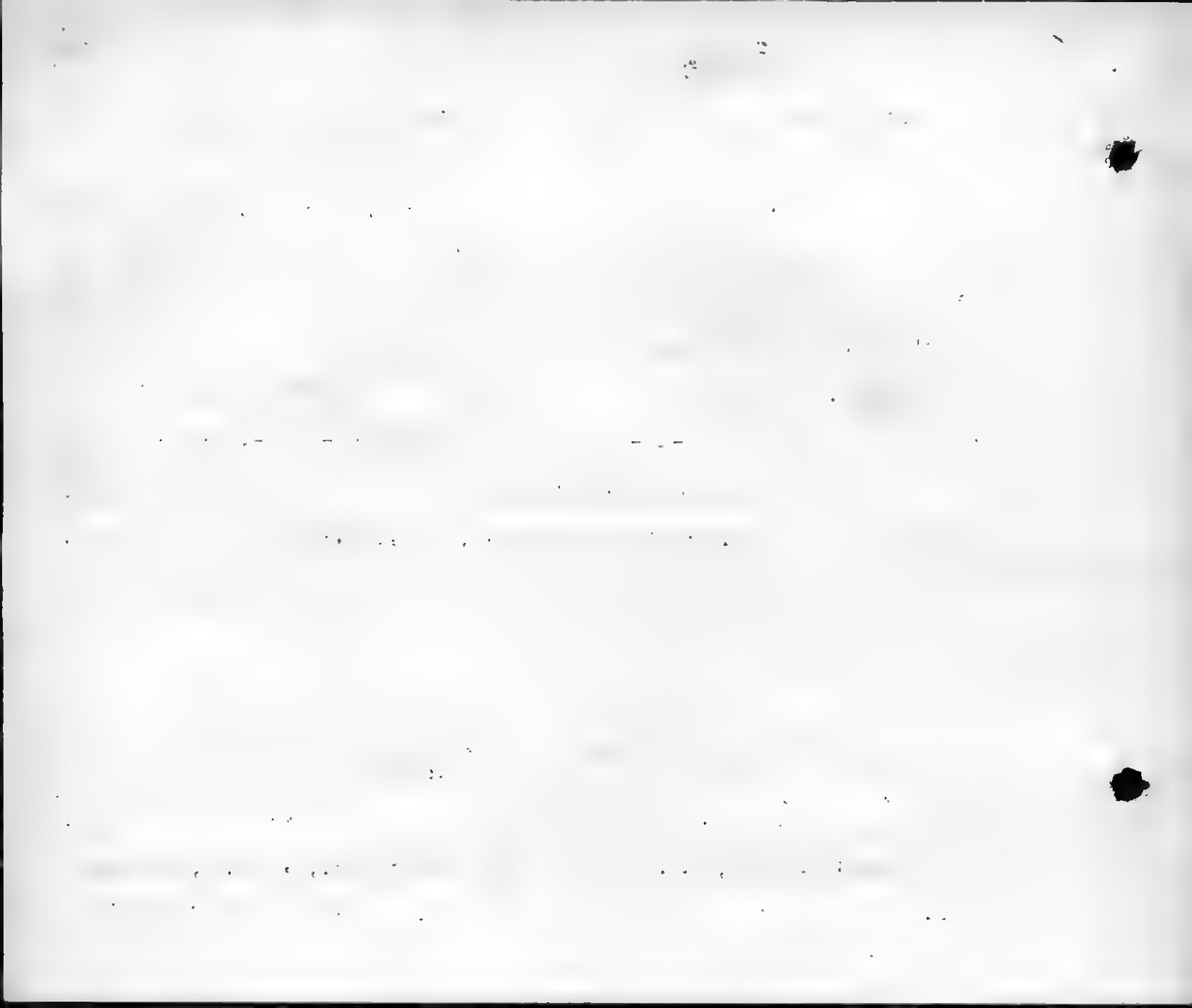
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8505 Lynnbrook Drive</b>		e. STREET ADDRESS <b>8505 Lynnbrook Drive</b>	
3. NAME OF DECEASED (Type or print) <b>EARL M. BROADHURST</b>		4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/4/1892</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>4</b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Helen's Doll Shop--Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George A. Broadhurst</b>		14. MOTHER'S MAIDEN NAME <b>Valie Dixon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>577-26-4114</b>	
INFORMANT <b>Helen Broadhurst-wife-same as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolization</b> <b>410X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Rheumatic Heart Disease, Mitral Stenosis</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>54 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 7</b> , 19 <b>47</b> , to <b>May 8</b> , 19 <b>59</b> that I last saw the deceased alive on <b>May 8</b> , 19 <b>59</b> , and that death occurred at <b>9:55P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert G. Angle</b>		ADDRESS (Street, city or town, state) <b>5009 Del Ray Ave., Bethesda, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Robert G. Angle, M.D.</b>		DATE SIGNED <b>5/9/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-11-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery.</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		24. REC'D BY REGISTRAR <b>MAY 12 '59</b>	
ADDRESS <b>Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





Items 18-20 Film 243 6-9-59 am.

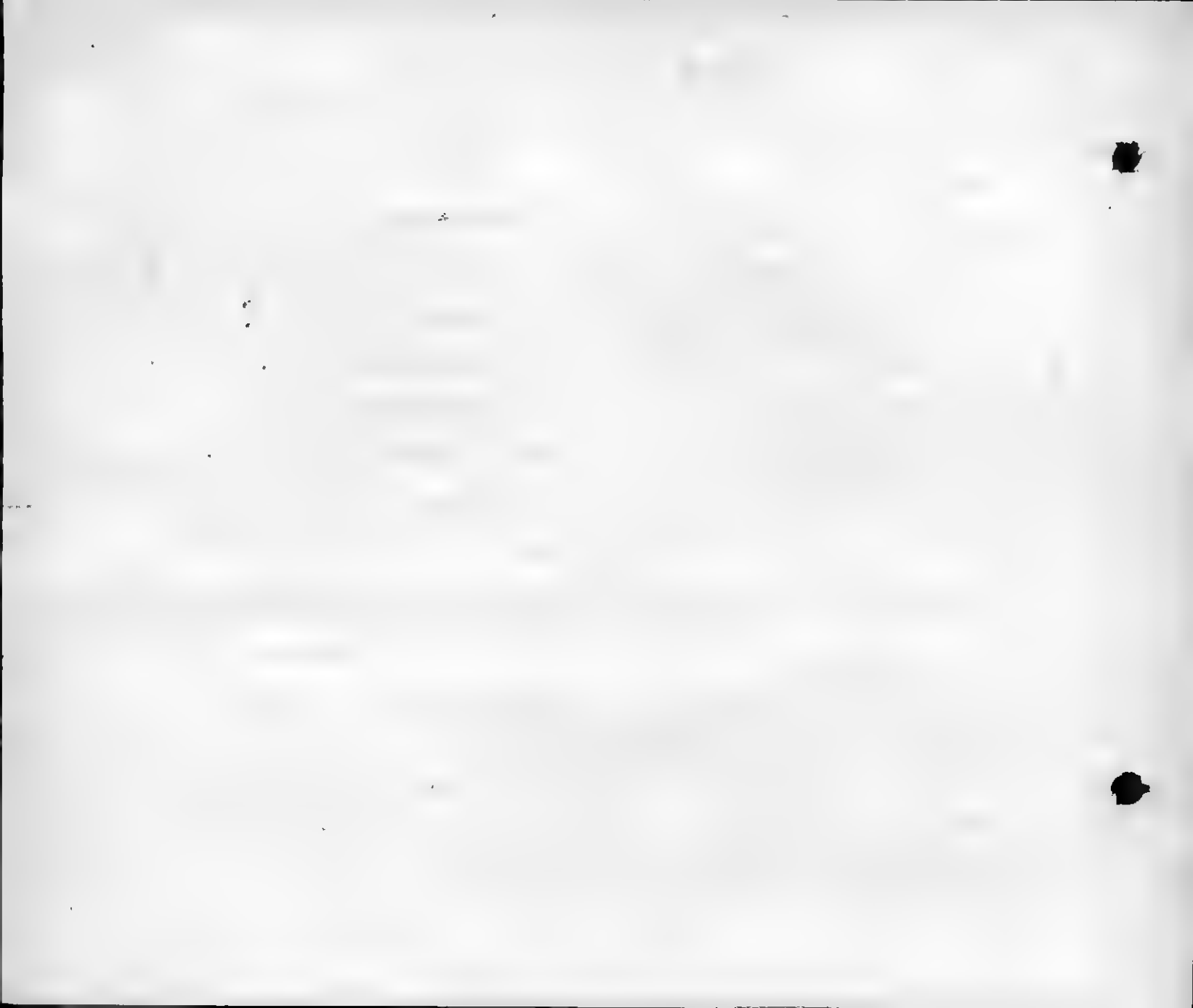
## Reg. Dist. No.

05716

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring</b>		c. LENGTH OF STAY IN 1b <b>17 days</b>	
d. NAME OF HOSPITAL (If not a hospital, give street address) <b>Brook Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Susan</b> Middle <b>Denise</b> Last <b>Brooks</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/28/59</b>
9 AGE (In years last birthday) yrs. <b>0</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>17</b>	IF UNDER 24 HRS Hours <b>17</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Allen Warfield Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Robinette Viola Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Record, Montgomery Co. Gen. Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangulation</b> <b>9210</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Aspiration of stomach contents</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Vomited and strangled</b>			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <b>6:05</b> p. m. <b>5 15 19 59</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>own home</b>		20f. (City or town) (County) (State) <b>Brooke Rd. Sandy Spr. Montg. Md.</b>	
21. I certify that I attended the deceased from <b>4/28</b> , 19 <b>59</b> , to <b>5/15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/15</b> , 19 <b>59</b> , and that death occurred at <b>5:30PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Sandy Spring, Md.</b> DATE SIGNED <b>5/17/59</b>			
ACTUAL SIGNATURE <b>C. H. Ligon</b> M.D. <b>C. H. Ligon</b>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/16/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sandy Spring</b>		22d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Lunden</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 20 '59</b>	
ADDRESS <b>Rockville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

may be retained by the hospital or attending physician.

➔ **FUNERAL DIRECTOR** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

item 1 1-11-59 et

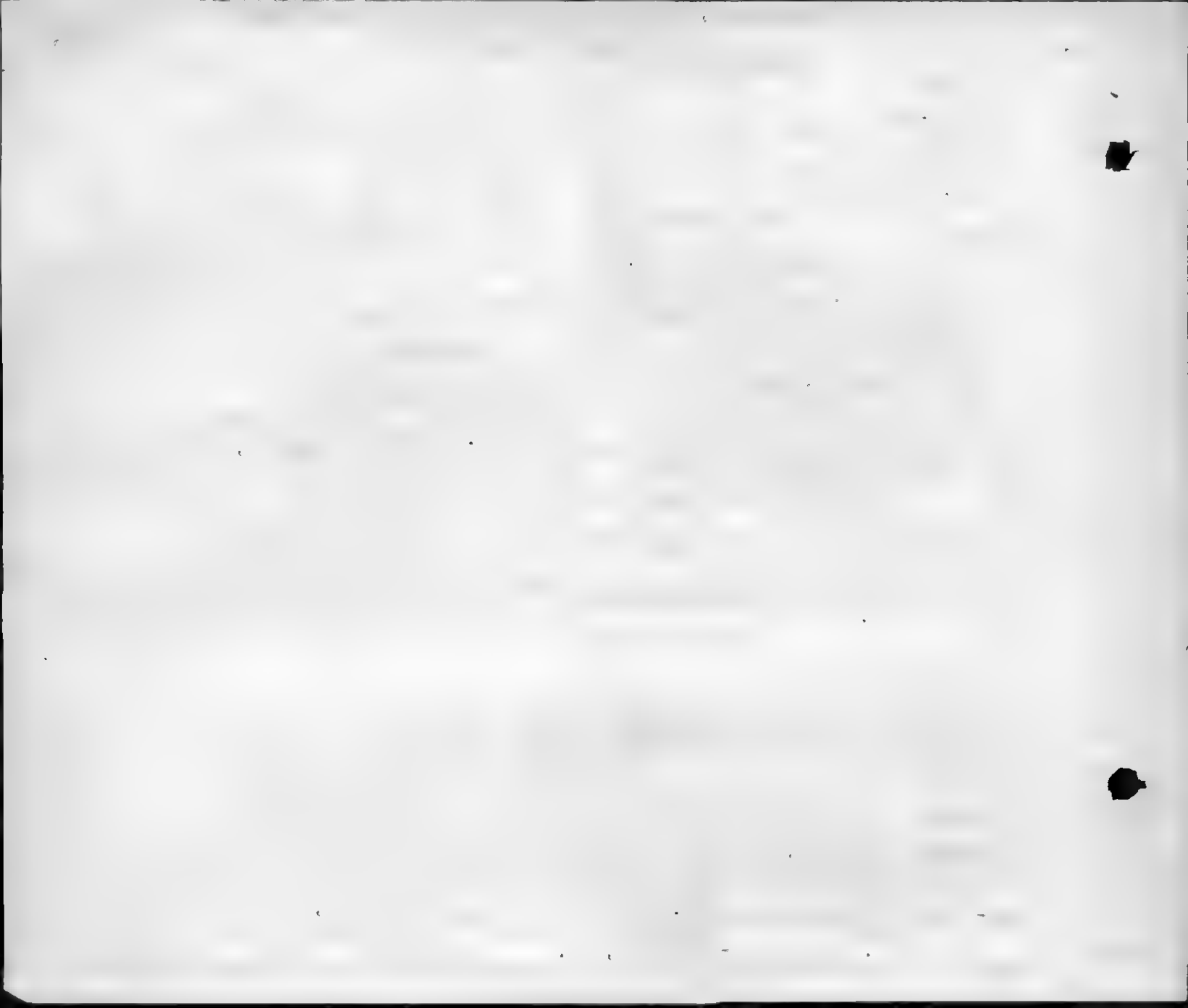
## CERTIFICATE OF DEATH

Reg. Dist. No.

05717

5740

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>Brooklyn</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9810 Georgia Avenue Lane Sanatorium</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Brooklyn</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b> d. STREET ADDRESS <b>4401 Clarendon Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALVINA</b> Middle <b>G.</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Connecticut</b>	
11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Merrath Bleichner</b>		14. MOTHER'S MAIDEN NAME <b>Celine Oberhaseur</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Benj. Newton</b>		Address <b>4700 Broad Brook Drive Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 4.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ESSENTIAL HYPERTENSION</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. 11.</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JUNE 24, 1958</b> , to <b>MAY 2, 1959</b> , that I last saw the deceased alive on <b>MAY 2, 1959</b> , and that death occurred at <b>7:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5206 NORMAN DR. 5/2/59</b> DATE SIGNED ACTUAL SIGNATURE <b>Henry M. Lowden</b> M.D. PHYSICIAN'S NAME (Type) <b>Henry M. Lowden</b> <b>Cheng Chong, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>	22b. DATE THEREOF <b>5/2/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>	22d. LOCATION (City, town, or county) (State) <b>Bronx, New York</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 5 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>



5741

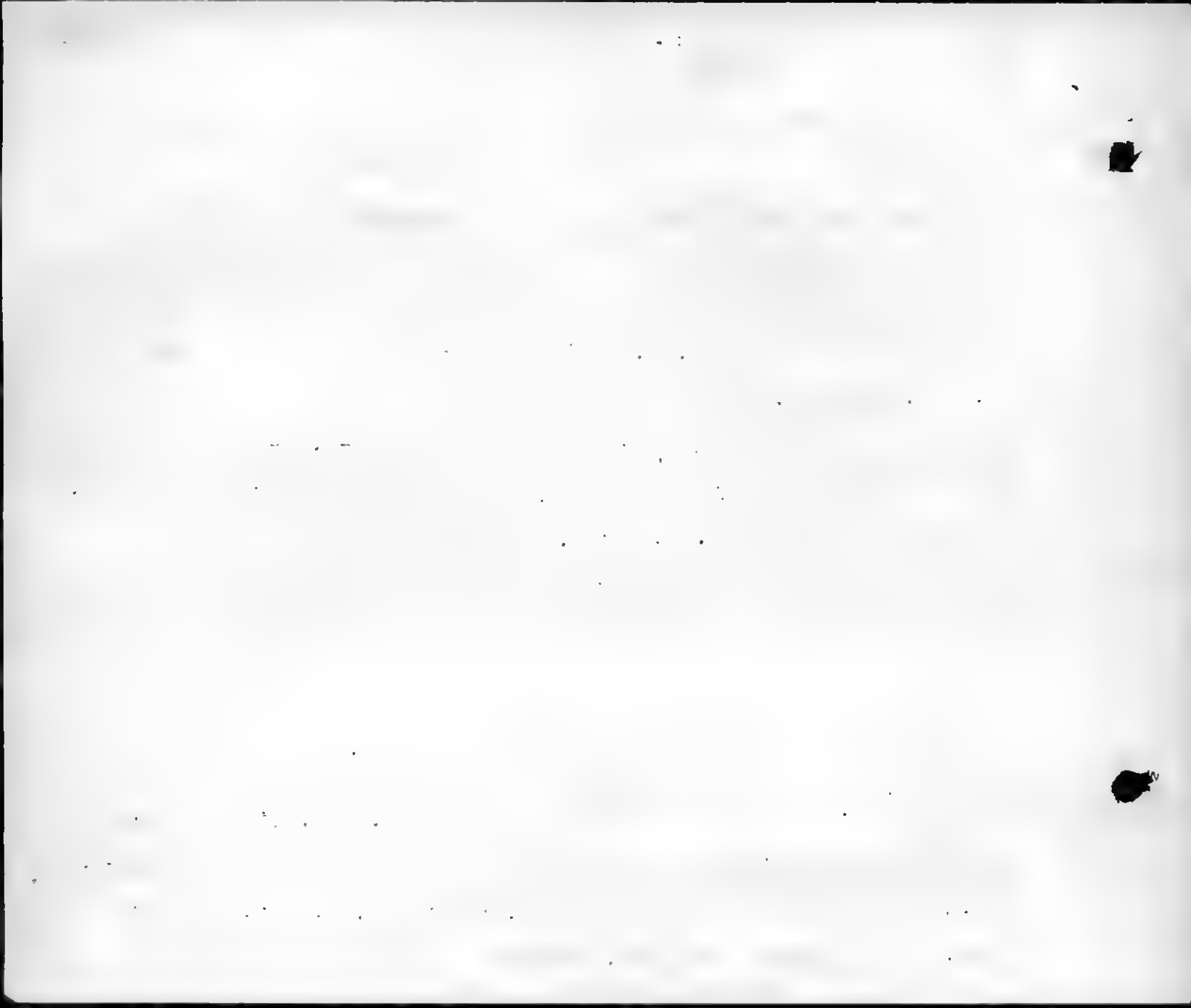
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3920 Baltimore Street</b>		d. STREET ADDRESS <b>3920 Baltimore Street</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>FREDERICK W BROWN</b>		4. DATE OF DEATH Month Day Year <b>May 25 19 59</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/31/1875</b>
9 AGE (In years last birthday) <b>83</b> yrs		IF UNDER 1 YEAR Months <b>4</b> Days <b>27</b>	IF UNDER 24 HRS Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't</b>	11. BIRTHPLACE (State or foreign country) <b>Michigan</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>Frederick T. Brown</b>	
14. MOTHER'S MAIDEN NAME <b>Annie Bates</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <b>Yes-Unknown</b>		INFORMANT <b>Fannie I Brown-wife-same as 2d</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary occlusion</b> (c) <b>Coronary atherosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5/20, 1959</b> to <b>5/25, 1959</b> , that I last saw the deceased alive on <b>5/22, 1959</b> , and that death occurred at <b>2:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald Nelson</b> M.D.		ADDRESS (Street, city or town, state) <b>10620 Ga. Ave. Silver Spring</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Donald Nelson</b>		<b>Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>5/27/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

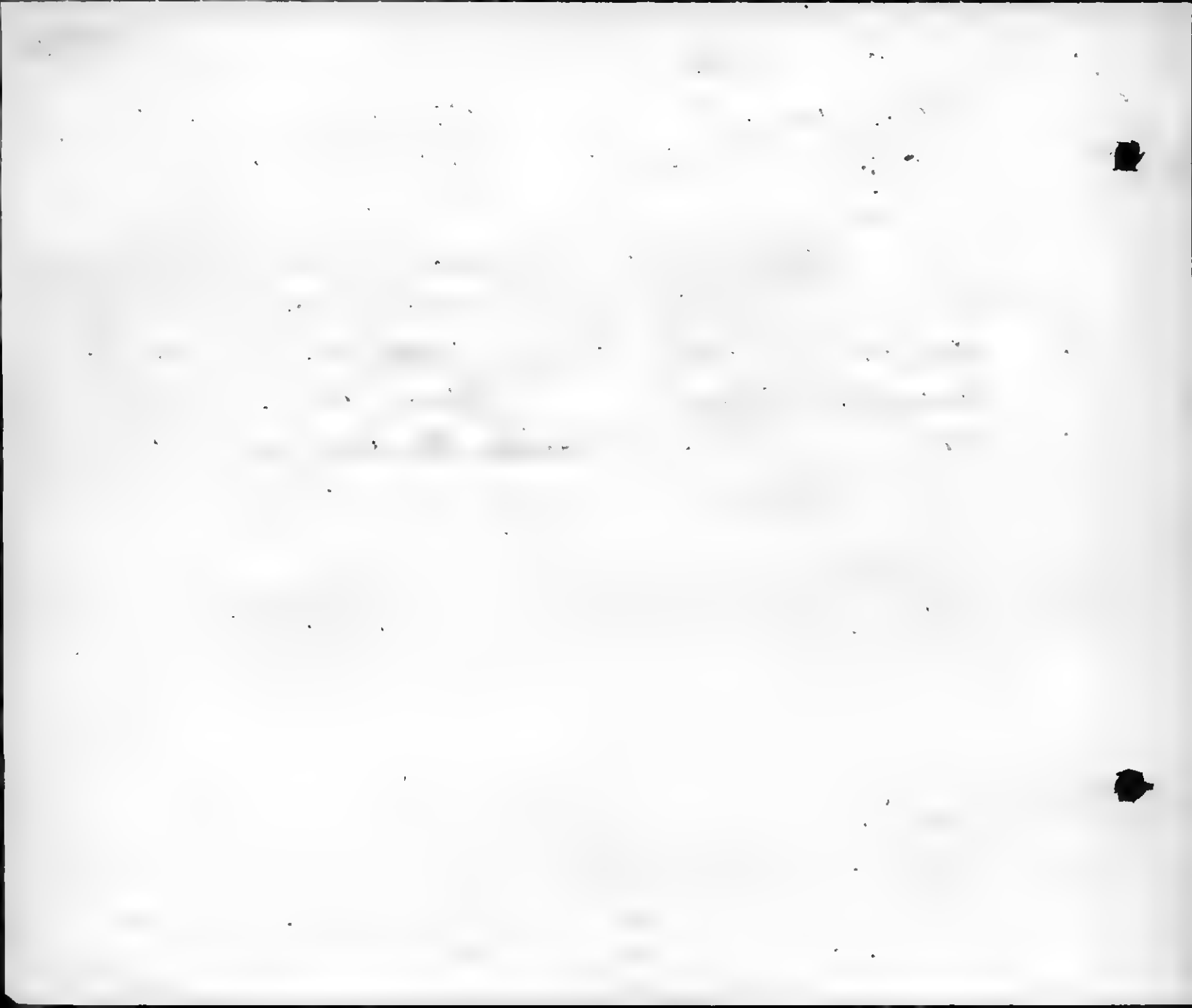
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5742 CERTIFICATE OF DEATH

Reg. Dist. No.

05719

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		14	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				1d. STREET ADDRESS <u>9905 Julliard Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>A.</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>5</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1890</u>		9. AGE (In years last birthday) yrs <u>68</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>6</u> Days <u>9</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Guthrie's Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Irving A. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Cunningham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-09-1984</u>		INFORMANT <u>Hilda Mae Newkirk</u>		Address <u>Daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Acute Coronary Thrombosis</u> DUE TO <u>immediate</u> (c) <u>Coronary Atherosclerotic Disease</u> DUE TO <u>1 month.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Prostate &amp; pelvic &amp; spine metastases.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 1958</u> to <u>May 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 14</u> , 19 <u>59</u> , and that death occurred at <u>9:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Blaine Fitzgerald</u>		M.D. <u>8218 Wisconsin Avenue</u>		ADDRESS (Street, city or town, state) <u>Bethesda, Maryland</u>		DATE SIGNED <u>5/26/59</u>	
PHYSICIAN'S NAME (Type) <u>J. Blaine Fitzgerald</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Hwang</u>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VM. A15ME  
SM. 2/57

FOR STATE  
HEALTH DEPT.

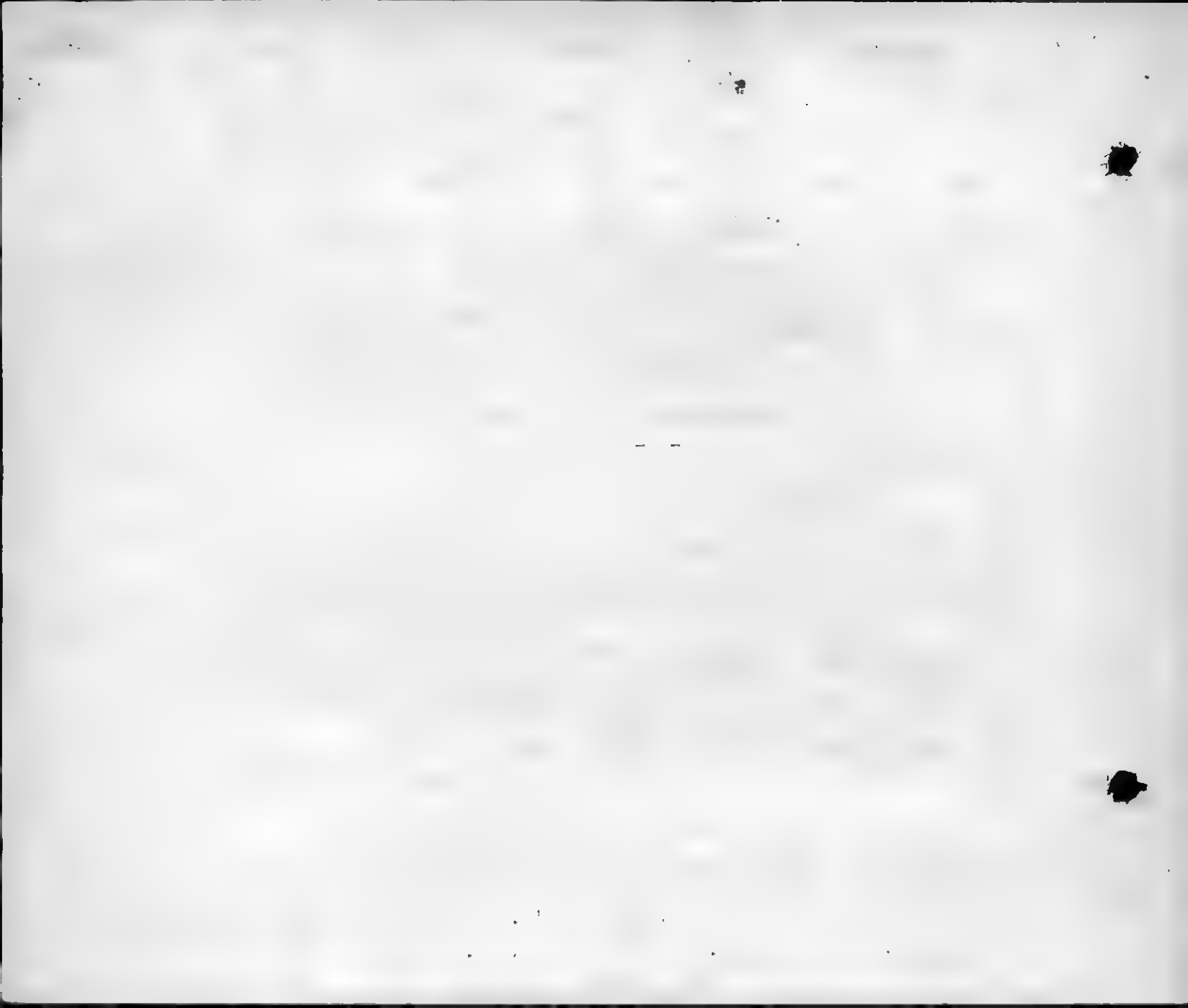
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5743

05720

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2710 Arcola Ave</u>			d. STREET ADDRESS <u>2710 Arcola Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Frederick Slater Butler Jr.</u>			4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1927</u>		9. AGE (In years, last birthday) <u>32</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>gas co.</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>Frederick S. Butler</u>			14. MOTHER'S MAIDEN NAME <u>Dune Bratton</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> WW # <u>2</u>		16. SOCIAL SECURITY NO. <u>578-30-6964</u>		17. INFORMANT <u>Letitia Butler (wife)</u> Address <u>Stem 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>774x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hanging</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Found hanging by neck in basement of his home</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	
		20f. (City or town) <u>Arlington</u>		20g. (County) <u>Virginia</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>May 30 1959</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>	
				22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5745 CERTIFICATE OF DEATH

05722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 1 - Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg Maryland</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs</u>		d. STREET ADDRESS <u>none</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Frederick CARL</u>		4. DATE OF DEATH Month Day Year <u>MAY 12 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1920</u>
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edmund O. Carl</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Beuchert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-14-4042</u>	
17. INFORMANT <u>Mrs. Sarah F. Carl</u>		Address <u>Route 1 - Gaithersburg</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction?</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Biliary Lithiasis?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 MIN</u> <u>3 MIN</u> <u>6 MIN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden Death - await autopsy report</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 8, 1956</u> to <u>12 MAY, 1959</u> , that I last saw the deceased alive on <u>12 MAY, 1959</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Boskey Ziegler</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>12 MAY 59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN BOSKEY ZIEGLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 15/59</u>	<u>Gate of Heaven</u>	<u>13705 - Gaithersburg Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Adams Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Clayton E. F...</u>	
ADDRESS <u>4746 - Wisconsin Ave Washington, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Clayton E. F...</u>	
DATE <u>MAY 15 '59</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5746

## CERTIFICATE OF DEATH

Reg. Dist. No.

05723

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dickerson</b> c. LENGTH OF STAY IN 1b <b>70 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dickerson</b> d. STREET ADDRESS <b>Rural</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Maurice</b> Last <b>Carlisle, Sr.</b>		4. DATE OF DEATH Month <b>5</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 4, 1889</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>70</b>	11. IF UNDER 24 HRS. Days <b>70</b> Hours <b>70</b> Min. <b>70</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm &amp; Dairy</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Richard C. Carlisle</b>		14. MOTHER'S MAIDEN NAME <b>Frances Appleby</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-38-3162</b>	
17. INFORMANT <b>Betty C. Carlisle</b>		Address <b>Dickerson, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion, acute</b> <b>420.1</b> DUE TO <b>Coronary arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> (c) <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b> <b>2 year</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5 Nov</b> , 19 <b>54</b> , to <b>19 May</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>19 May</b> , 19 <b>59</b> , and that death occurred at <b>10:40 P. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gordon M. Smith</b>		ADDRESS (Street, city or town, state) <b>Barnesville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Gordon M. Smith</b>		DATE SIGNED <b>21 May 59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/22/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>	22d. LOCATION (City, town, or county) (State) <b>Beallsville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Hilton</b>		24. REC'D BY REGISTRAR <b>MAY 25 '59</b>	
ADDRESS <b>Barnesville Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	





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VS A15 (4)  
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05724

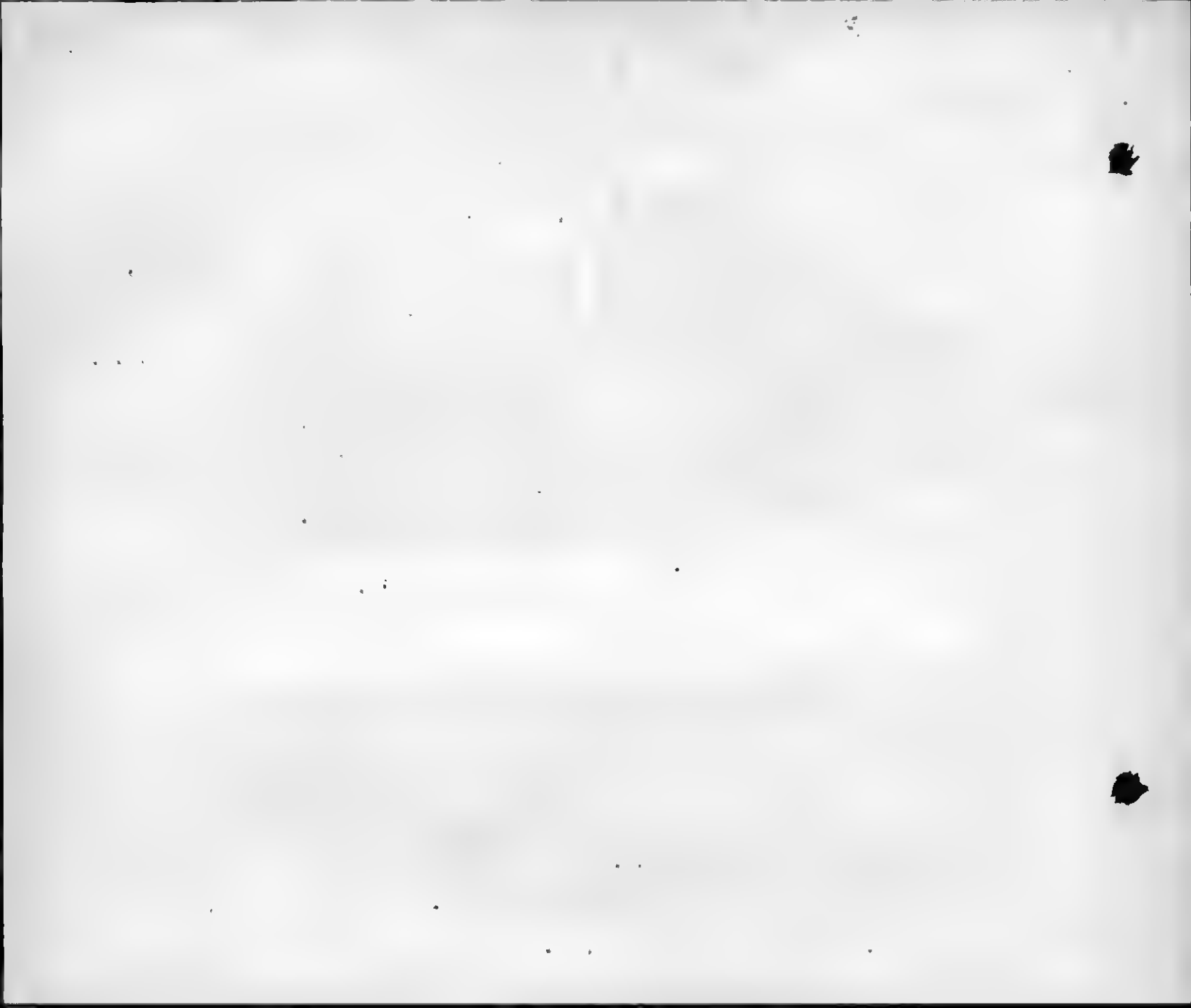
Reg. Dist. No.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5747

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>11 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Adena</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adena</b> d. STREET ADDRESS <b>Rural Delivery 1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Jane</b> Last <b>Carpenter</b>			4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 31, 1947</b>	9. AGE (In years last birthday) <b>11</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>			
13. FATHER'S NAME <b>Andrew Carpenter</b>			14. MOTHER'S MAIDEN NAME <b>Nettie Williams</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Severe Congestive Heart Failure following complete repair of Tetralogy of Fallot.</b> DUE TO <b>Severe Polycythemia secondary to Tetralogy of Fallot.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Subacute Bacterial Endocarditis.</b> (c) <b>Subacute Bacterial Endocarditis.</b>					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>May 12</b> , 19 <b>59</b> , to <b>May 23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 23</b> , 19 <b>59</b> , and that death occurred at <b>3:00 A</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5/23/59</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)		22b. DATE THEREOF <b>5/26/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Alexandria Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Alexandria, Ohio</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>MAY 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		



1  
FOR STATE  
HEALTH DEPT.

5748

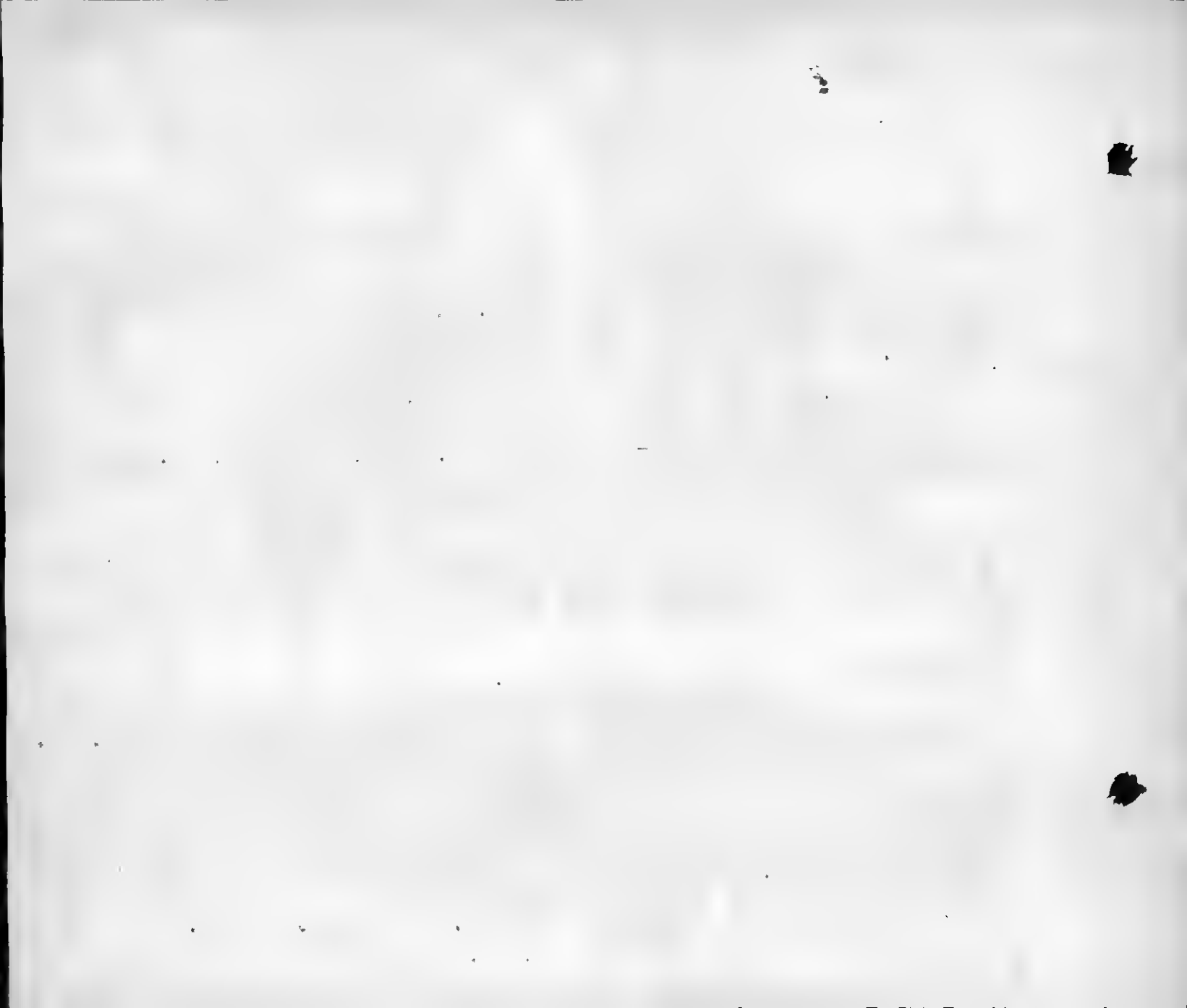
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05725

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD Monrovia</b>		c. LENGTH OF STAY IN 1b <b>years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>Pearl</b> Last <b>Clay</b>		4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 6, 1908</b>
9. AGE (in years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>30</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Prop.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Resturant</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward King</b>		14. MOTHER'S MAIDEN NAME <b>Jessie Ridgley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>218-30-9974</b>	
17. INFORMANT <b>Wilson E. Clay, Monrovia, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thoracic and cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bullet wounds in left chest and base of left skull</b> DUE TO (c) <b>few minutes</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Was shot by husband</b>	
20c. TIME OF INJURY Month, Day, Year <b>8:29 PM 5/30/59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>RFD, Monrovia, Montg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		DATE SIGNED <b>5/30/59</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 2, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Providence Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Kempton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas. L. Molisanti</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 3 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



5749

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

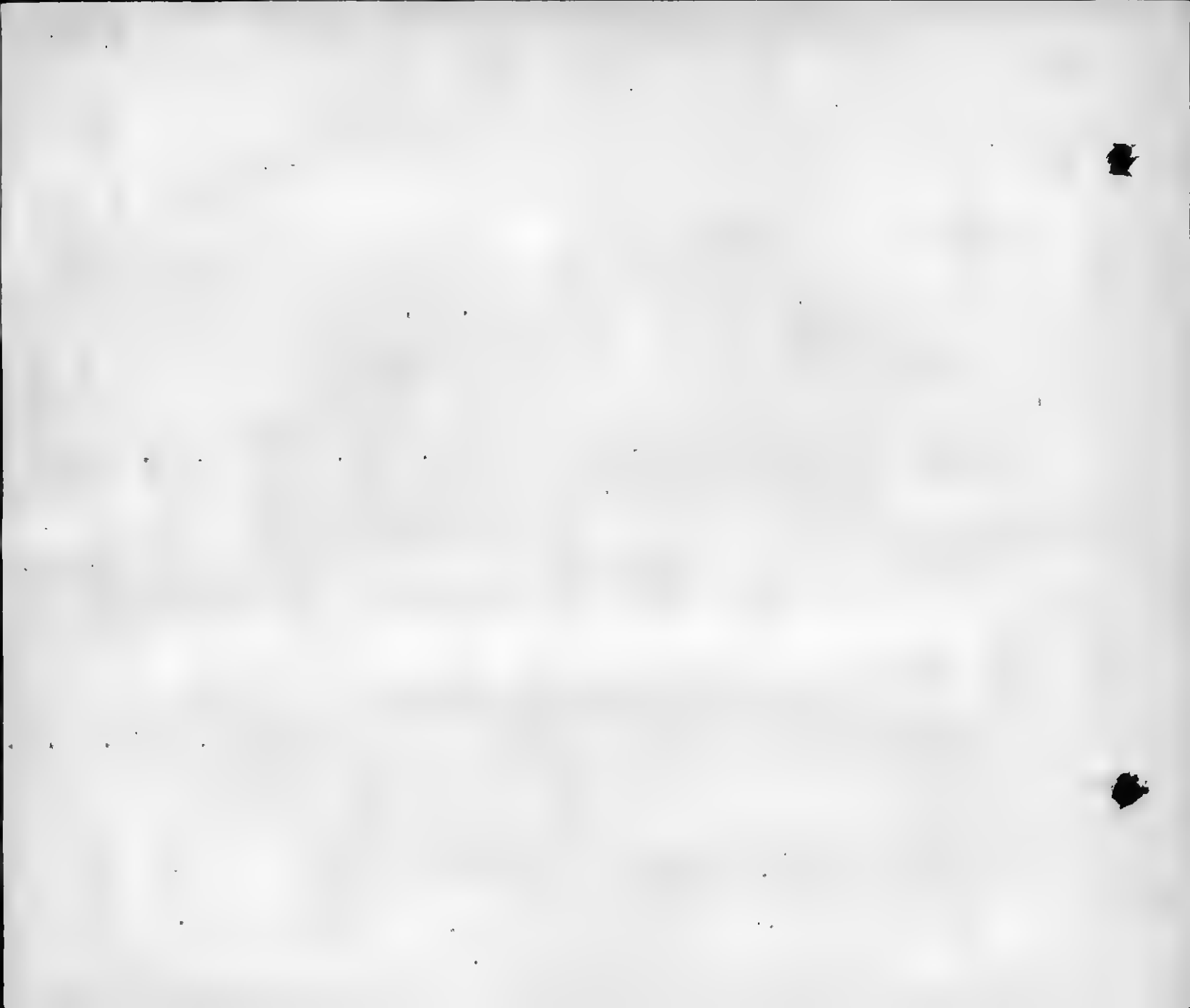
05726

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD Monrovia</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>RFD Monrovia</b>	
3. NAME OF DECEASED (Type or print) First <b>Wilson</b> Middle <b>Carroll</b> Last <b>Clay</b>		4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, 1901</b>
9. AGE (in years last birthday) <b>57 yrs</b>		10. IF UNDER 1 YEAR Months <b>57</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Harry Clay</b>		14. MOTHER'S MAIDEN NAME <b>Ella Rhinehart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>217-36-7843</b>	
17. INFORMANT <b>Wilson E. Clay, Monrovia, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thoracic and cerebral hemorrhage</b> <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Bullet wounds in left chest and</b> (c) <b>right skull</b> DUE TO cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>Self inflicted bullet wounds</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Few minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Self inflicted bullet wounds</b>	
20c. TIME OF INJURY Month, Day, Year <b>8:30 PM 5/30/59</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>RFD Monrovia, Montg. Co. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>5/30/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 2, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Providence Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Kempton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. McSwain</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 3 '59</b>	
ADDRESS <b>Damascus, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

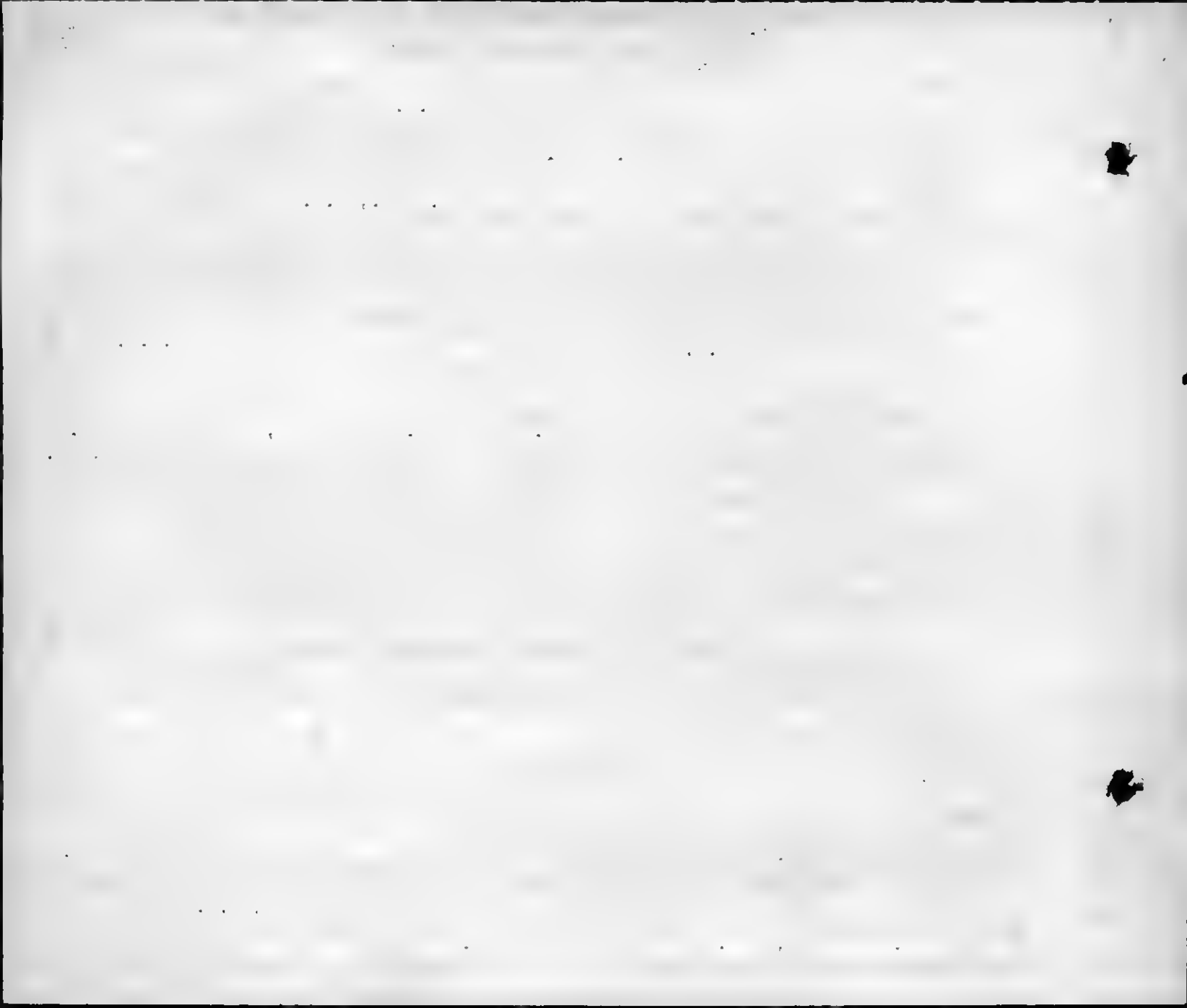
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5750 CERTIFICATE OF DEATH

05727

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MAPLE LANE NURSING HOME</b>				d. STREET ADDRESS <b>644 MASS. AVE., N.E.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>ELIZABETH</b> Last <b>COBURN</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>8</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/11/74</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bureau of Engraving U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>RICHARD FREE</b>				14. MOTHER'S MAIDEN NAME <b>ROSELLA GOODWIN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Dorothy C. Carmichael, 8408 Houston St. Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>444X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>ESSENTIAL HYPERTENSION</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>AUG 14</b> , 19 <b>56</b> , to <b>MAY 8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>MAY 8</b> , 19 <b>59</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5206 Norway Dr.</b> DATE SIGNED <b>Cherry Chase, Md. 5/8/59</b>							
ACTUAL SIGNATURE <b>Henry M. Lowden</b> M.D.				PHYSICIAN'S NAME (Type) <b>HENRY M. LOWDEN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/11/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. POMPHELY, INC.</b> <b>Raymond A. Biska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 15 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			





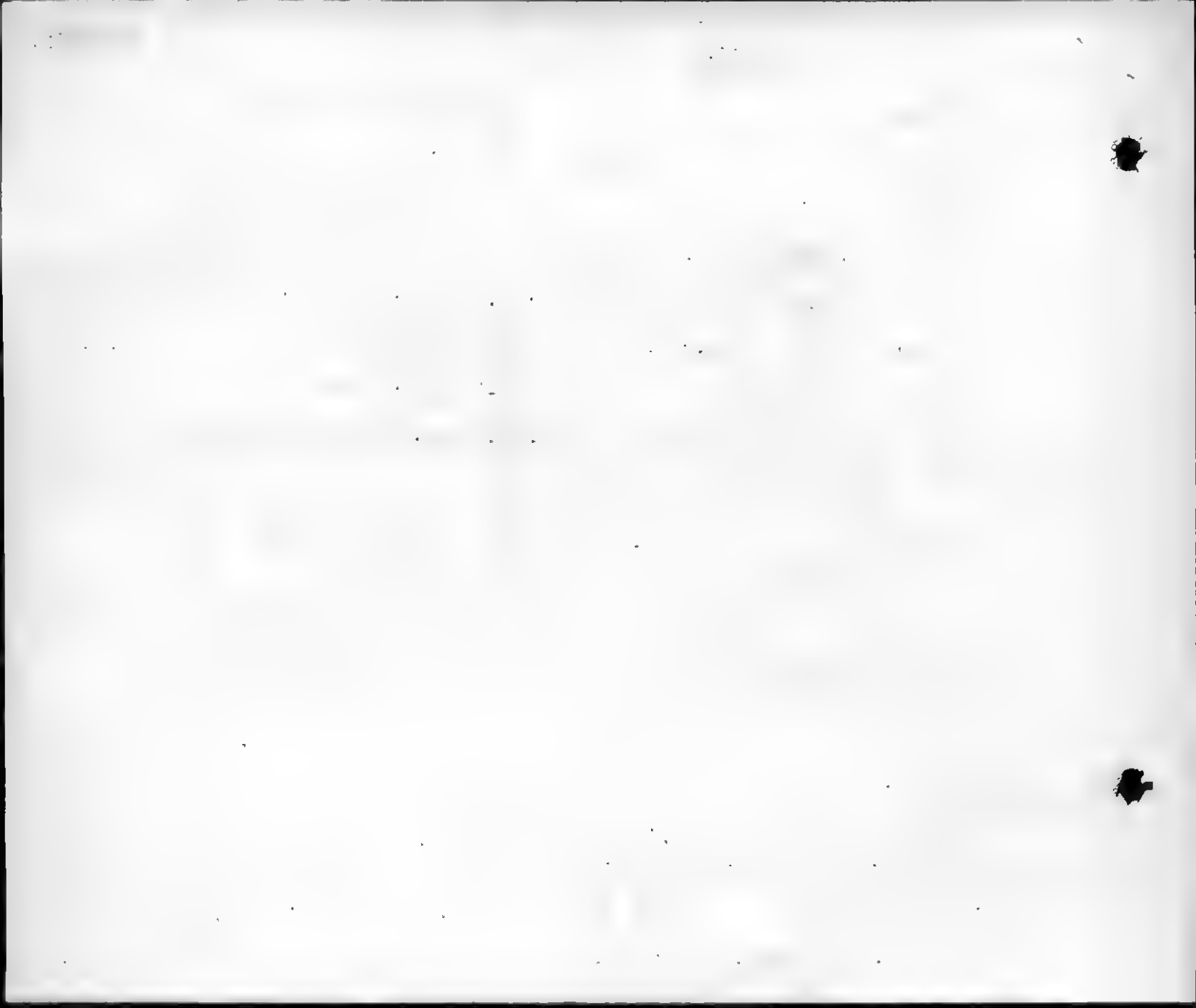
## 5751 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) c. STATE <b>Maryland</b> d. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>6 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4344 East West Highway</b>		e. STREET ADDRESS <b>4344 East West Highway</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mildred A. Cook</b>		4. DATE OF DEATH Month Day Year <b>May 29, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 30, 1868</b>
9. AGE (In years last birthday) <b>91 yrs.</b>		10. IF UNDER 1 YEAR Months Days <b>5 29</b>	11. IF UNDER 24 HRS. Hours Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wathan Marple</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Dickinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Dr. E. Russell Cook-Item #2-son</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary congestion, acute</b> <b>420.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> , 19____, to <b>29 May, 1959</b> that I last saw the deceased alive on <b>29 May</b> , 19____, and that death occurred at <b>4:30 P.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7659 Old Georgetown Road Bethesda, Maryland</b> DATE SIGNED <b>6/1/59</b>			
ACTUAL SIGNATURE <b>John M. Wyman, M. D.</b>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMAT., OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/2/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>XXX Ivy Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Alexandria, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: File law requiring that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05729

## 5752 CERTIFICATE OF DEATH

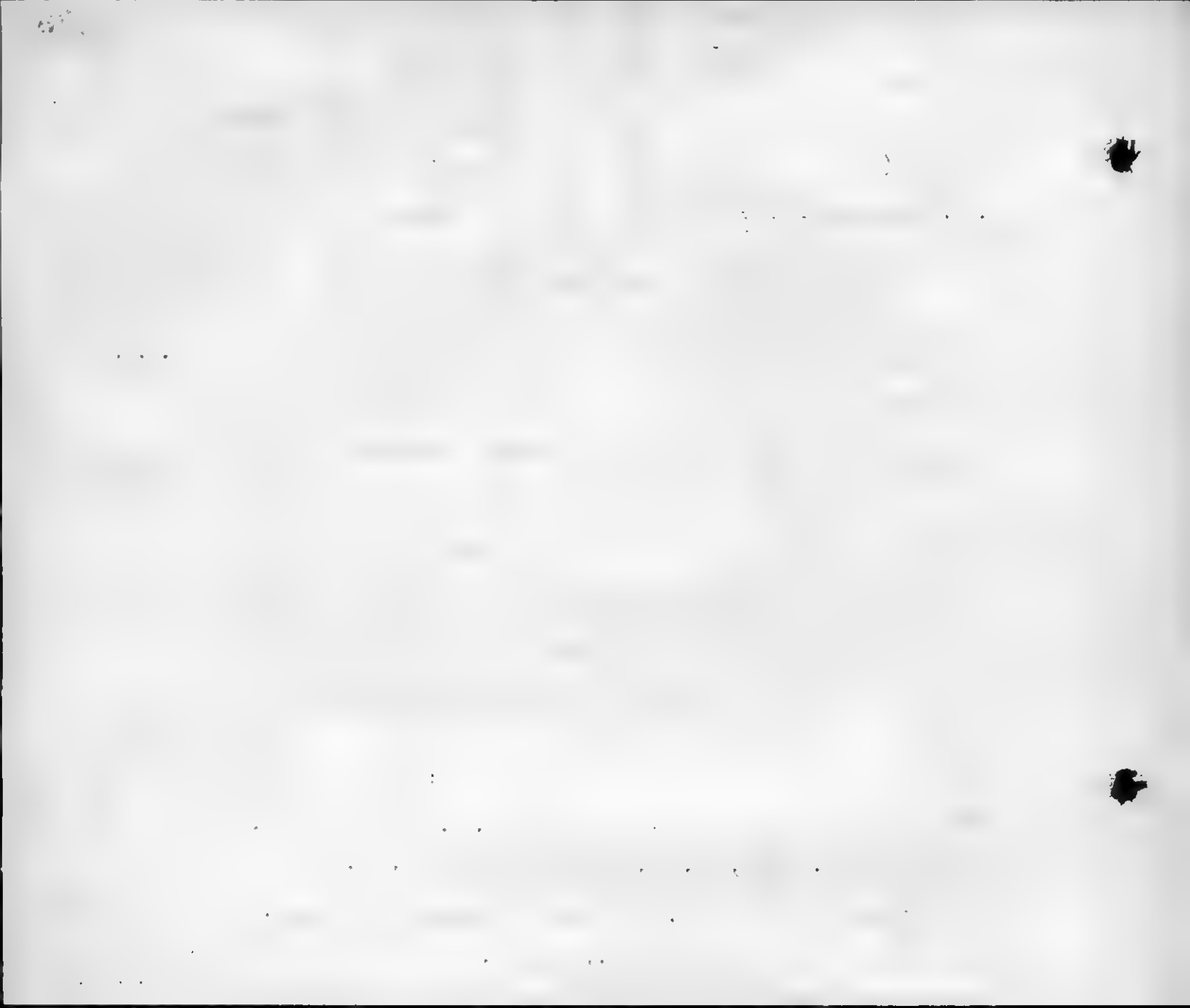
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>17 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Texas</b> b. COUNTY <b>Kleberg</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville</b> d. STREET ADDRESS <b>1100 East Lott</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Cheryl Ann COOLEY</b>				4. DATE OF DEATH Month Day Year <b>May 12 19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-11-59</b>	
9. AGE (In years last birthday) yrs. <b>3</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b></b> Min. <b></b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Cooley</b>		14. MOTHER'S MAIDEN NAME <b>Geraldine Pedron</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart Block + Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Ventricular</b> (c) <b>Congenital Heart Disease Septal Defect + Coronary Artery Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	
20f. (City or town) <b></b>				20g. (County) <b></b>		20h. (State) <b></b>	
21. I certify that I attended the deceased from <b>April 25</b> , 19 <b>59</b> , to <b>May 12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 12</b> , 19 <b>59</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John H. Mazur</b>				ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b>		DATE SIGNED <b>5-13-59</b>	
PHYSICIAN'S NAME (Type) <b>John H. MAZUR, LT, MC, USN</b>				<b>Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		22b. DATE THEREOF <b>5-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's of the Assumption</b>		22d. LOCATION (City, town, or county) (State) <b>Kulpmont Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Collins Funeral Home</b>				ADDRESS <b>3821 14th St., NW, Wash. DC</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 14 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5753

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>				d. STREET ADDRESS <b>3112 S. Hayes Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Michael CORLE</b>				4. DATE OF DEATH Month Day Year <b>May 5 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-3-59</b>	
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months Days Hours Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph S. CORLE</b>		14. MOTHER'S MAIDEN NAME <b>Gloria Loraine REINHART</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral anoxia secondary to fetal atelectasis and hyaline disease.</b> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U. S. Naval Hospital</b>	
20f. (City or town) <b>Bethesda</b>				20g. (County) <b>Montgomery</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>May 3 1959</b> , to <b>May 5 1959</b> , that I last saw the deceased alive on <b>May 4 1959</b> , and that death occurred at <b>3:05A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Bethesda 14, Maryland</b> DATE SIGNED <b>5-5-59</b>							
ACTUAL SIGNATURE <b>H. L. Walton</b>				M.D. <b>U. S. Naval Hospital</b>			
PHYSICIAN'S NAME (Type) <b>H. L. WALTON, LT, MC, USN</b>				ADDRESS <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-8-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18 2 4

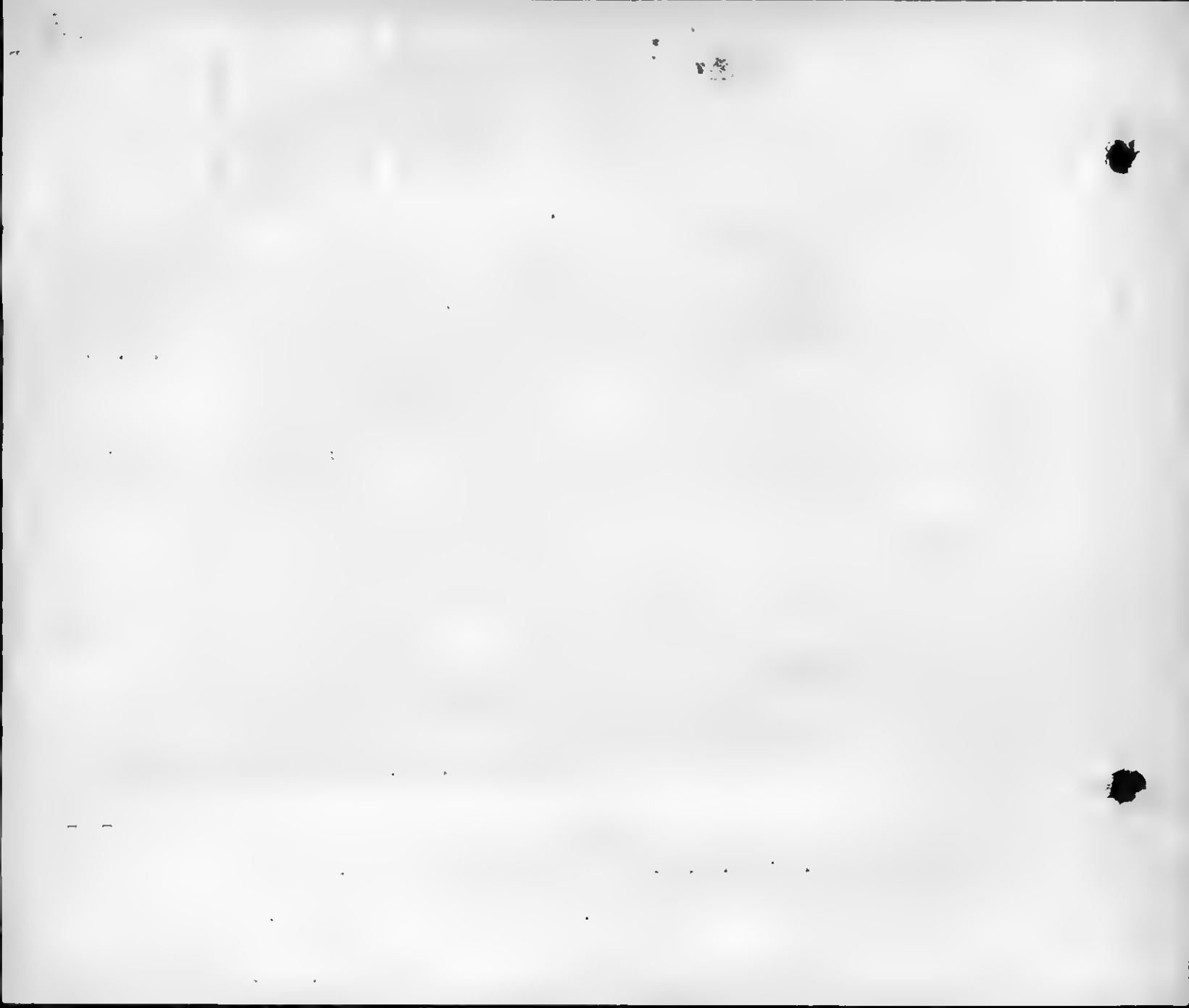


5754

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Kentucky</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN TB <b>46 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Avawam</b>		<b>55x3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>(None)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Ira</b>		Middle <b>(None)</b>		Last <b>Cornett</b>	
4. DATE OF DEATH		Month <b>May</b>		Day <b>18,</b>		Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>July 1, 1918</b>		9. AGE (In years last birthday) yrs <b>40</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tonsorial</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Cornett</b>				14. MOTHER'S MAIDEN NAME <b>Polly Hoskins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>Unavailable</b>		17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> <b>4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Vascular Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 2, 1959</b> to <b>May 18, 1959</b> , that I last saw the deceased alive on <b>May 18, 1959</b> , and that death occurred at <b>7:05 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John A. Oates, M.D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b>		DATE SIGNED <b>5-19-59</b>			
PHYSICIAN'S NAME (Type) <b>John A. Oates, M. D.</b>				<b>National Institutes of Health</b>		<b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>5-19th. 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery.</b>		22d. LOCATION (City, town, or county) (State) <b>Hazard Ky.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Demaine &amp; Son.</b>				ADDRESS <b>Alexandria Va.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			





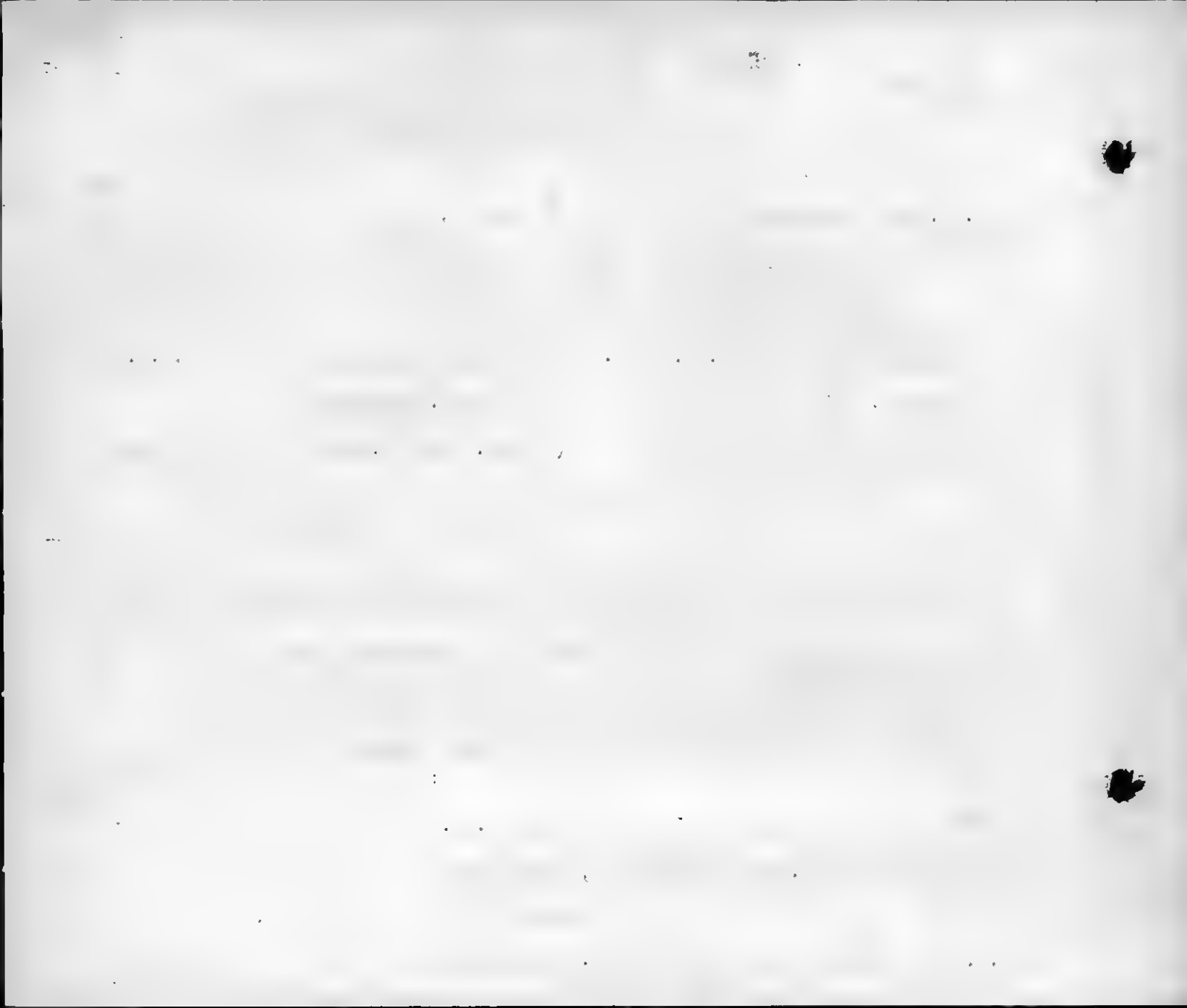
5755

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Lorton</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lorton</b> d. STREET ADDRESS <b>RR #1, Box 70</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Howell Gardner CRIM</b>				4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-2-98</b>	
9. AGE (In years last birthday) <b>60</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Usher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>			
13. FATHER'S NAME <b>William S. Crim</b>				14. MOTHER'S MAIDEN NAME <b>Mary B. Hoffmaster</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>WWI</b>		17. INFORMANT <b>(W) Mrs. Sadie M. Crim, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary fibrosis, etiol. undet.</b> DUE TO (c) <b>10 yrs +</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Bethesda</b>		(County) <b>Maryland</b>		(State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>May 3</b> 19 <b>59</b> , to <b>May 11</b> 19 <b>59</b> , that I last saw the deceased alive on <b>May 9</b> 19 <b>59</b> , and that death occurred at <b>5:35A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Joseph T. Horgan</b>		M.D. <b>U. S. Naval Hospital</b>		ADDRESS (Street, city or town, state) <b>Bethesda 14, Maryland</b>		DATE SIGNED <b>5-11-59</b>	
PHYSICIAN'S NAME (Type) <b>Joseph T. HORGAN, LCDR, MC, USN</b>		22a. NAME OF CEMETERY OR CREMATORY <b>Popick Cemetery</b>		22b. LOCATION (City, town, or county) <b>Fairfax Co. Virginia</b>		(State)	
22c. NAME OF CEMETERY OR CREMATORY <b>Popick Cemetery</b>		22d. LOCATION (City, town, or county) <b>Fairfax Co. Virginia</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. Hines</b>		24a. REC'D BY REGISTRAR <b>MAY 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G243 6-2-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

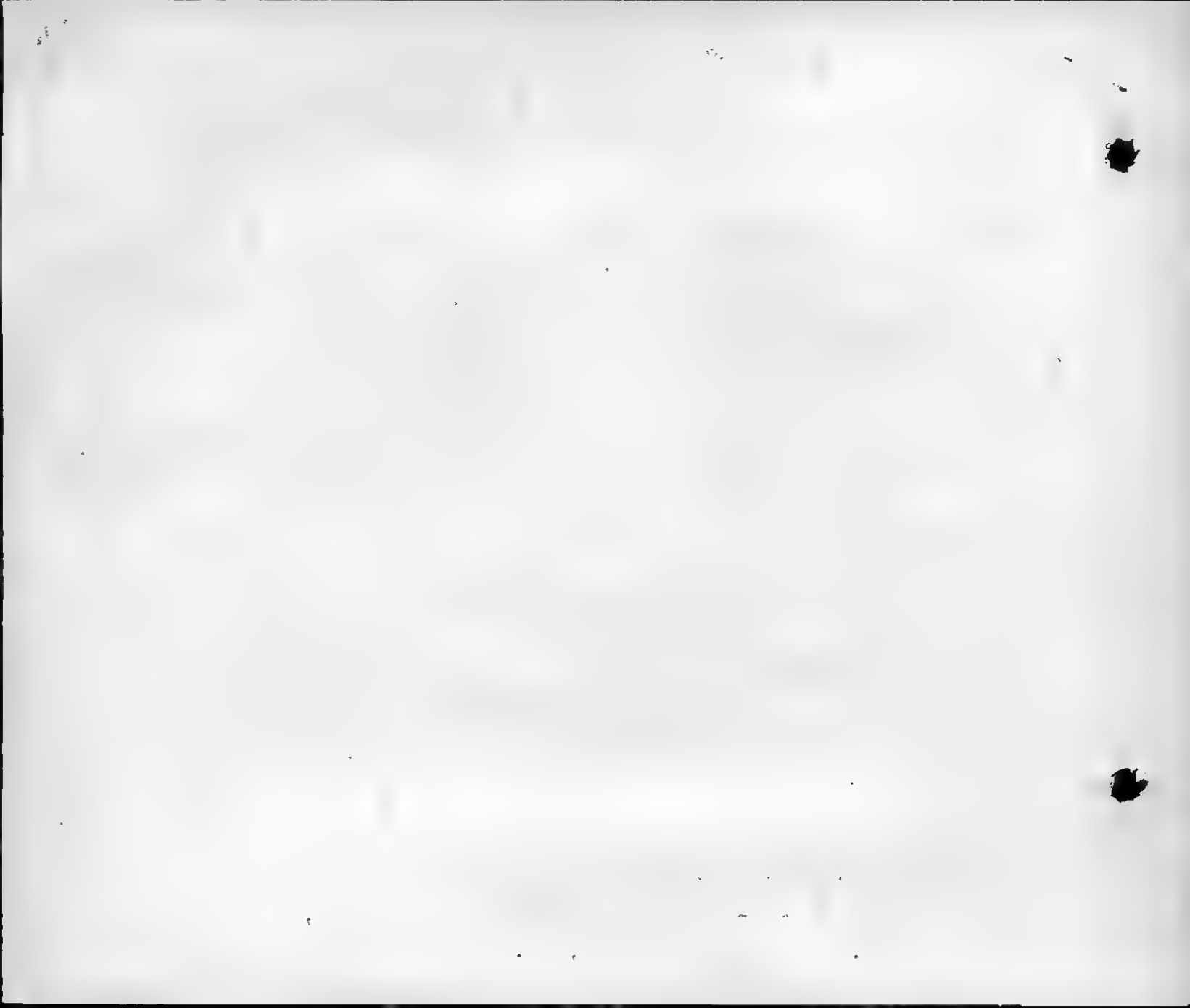
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1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDNOR</b> c. LENGTH OF STAY IN 1b <b>EDNOR</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BELMONT NURSING HOME</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDNOR</b> d. STREET ADDRESS <b>Colesville Road, Rt. # 29</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>R.</b> Last <b>CRUM</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>23</b> Year <b>19 59</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/26/81</b>	9. AGE (In years last birthday) <b>77</b> yrs.	10. IF UNDER 1 YEAR Months <b>77</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doctor - Osteopathic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Michigan</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		
13. FATHER'S NAME <b>? Gates</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>BELMONT NURSING HOME RECORDS EDNOR, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS</b> DUE TO (c) <b>NEPHRITIS</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b>  <b>YEARS</b>  <b>YEARS</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>DECEMBER 1, 19 58</b> , to <b>MAY 18, 19 59</b> , that I last saw the deceased alive on <b>MAY 18, 19 59</b> , and that death occurred at <b>10:10 A.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. W. BIRD, M. D.</b>		M. D. <b>Sandy Spring, Md.</b>		ADDRESS (Street, city or town, state) <b>SANDY SPRING, MARYLAND</b> DATE SIGNED <b>5/23/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 5-25-59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Ames City Cemetery</b>			
22d. LOCATION (City, town, or county) (State) <b>Ames, Iowa</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		24a. REC'D BY REGISTRAR <b>Bethesda, Md.</b> 24b. REGISTRAR'S SIGNATURE <b>Clair &amp; House</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5757 CERTIFICATE OF DEATH

05734

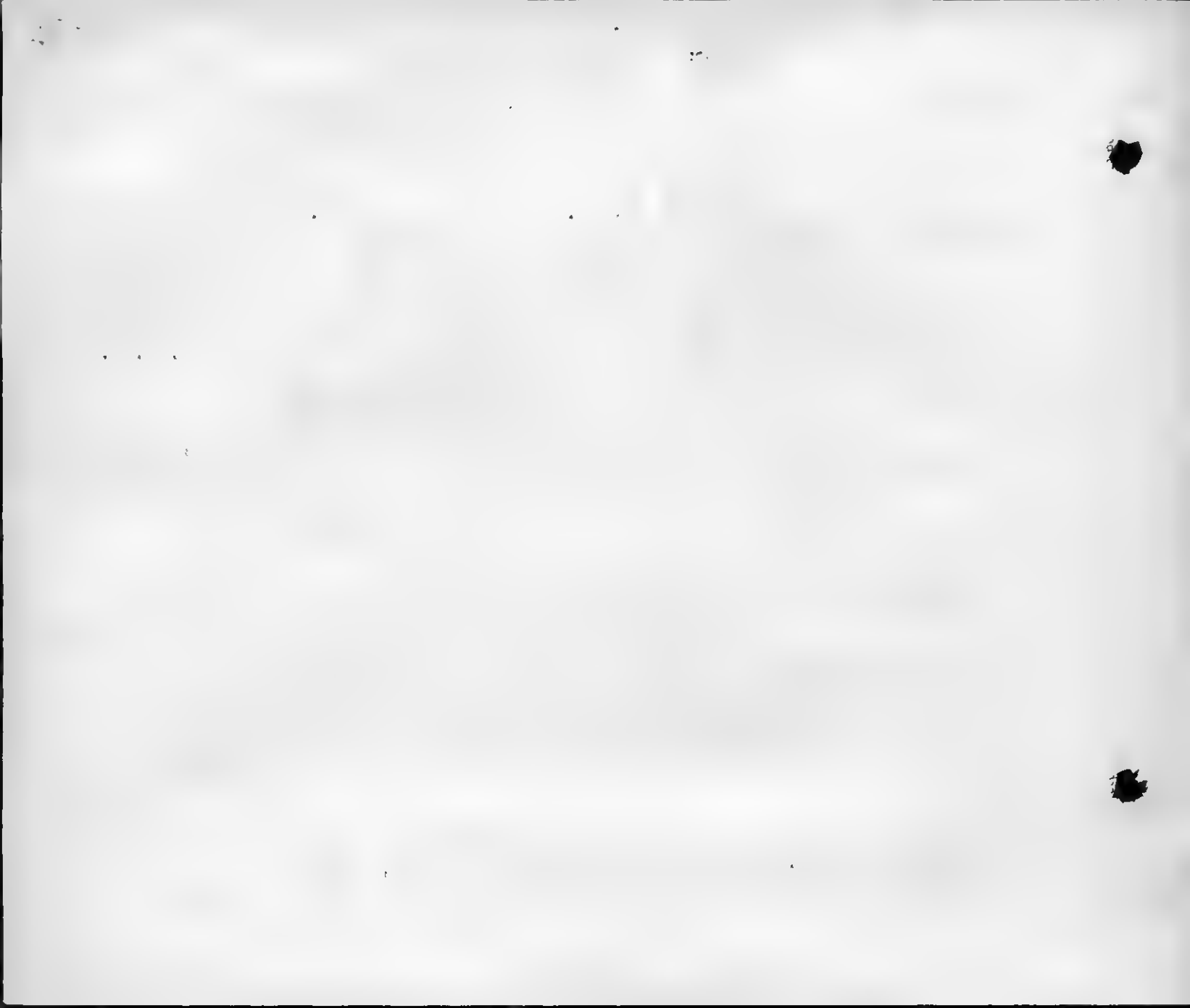
Reg. Dist. No.

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) STATE <b>District of Columbia</b> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>11 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>518 E Street, S. E.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Gertrude</b>		First <b>(none)</b>		Middle <b>Culver</b>		Last	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 7, 1886</b>	
9. AGE (In years last birthday) <b>72</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Holland</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13. FATHER'S NAME <b>John Poll</b>		14. MOTHER'S MAIDEN NAME <b>Boukye van der Meulen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unavailable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Necrotizing hepatitis etiology</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>undetermined</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>April 24</b> , 19 <b>59</b> , to <b>May 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 5</b> , 19 <b>59</b> , and that death occurred at <b>2:15 P.</b> M. from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5/5/59</b> ACTUAL SIGNATURE <b>Howard M. Radwin, M.D.</b> PHYSICIAN'S NAME (Type) <b>Howard M. Radwin, M. D.</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, OR OTHER DISPOSITION <b>Interred</b>				22b. DATE THEREOF <b>5-8-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	
22d. LOCATION (City, town, or county) <b>Suitland, Md.</b>				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. William Lee's Sons Co.</b>				ADDRESS <b>300-4th St. N. E.</b>		24a. REC'D BY REGISTRAR <b>MAY 7 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>				24c. (State)			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05735

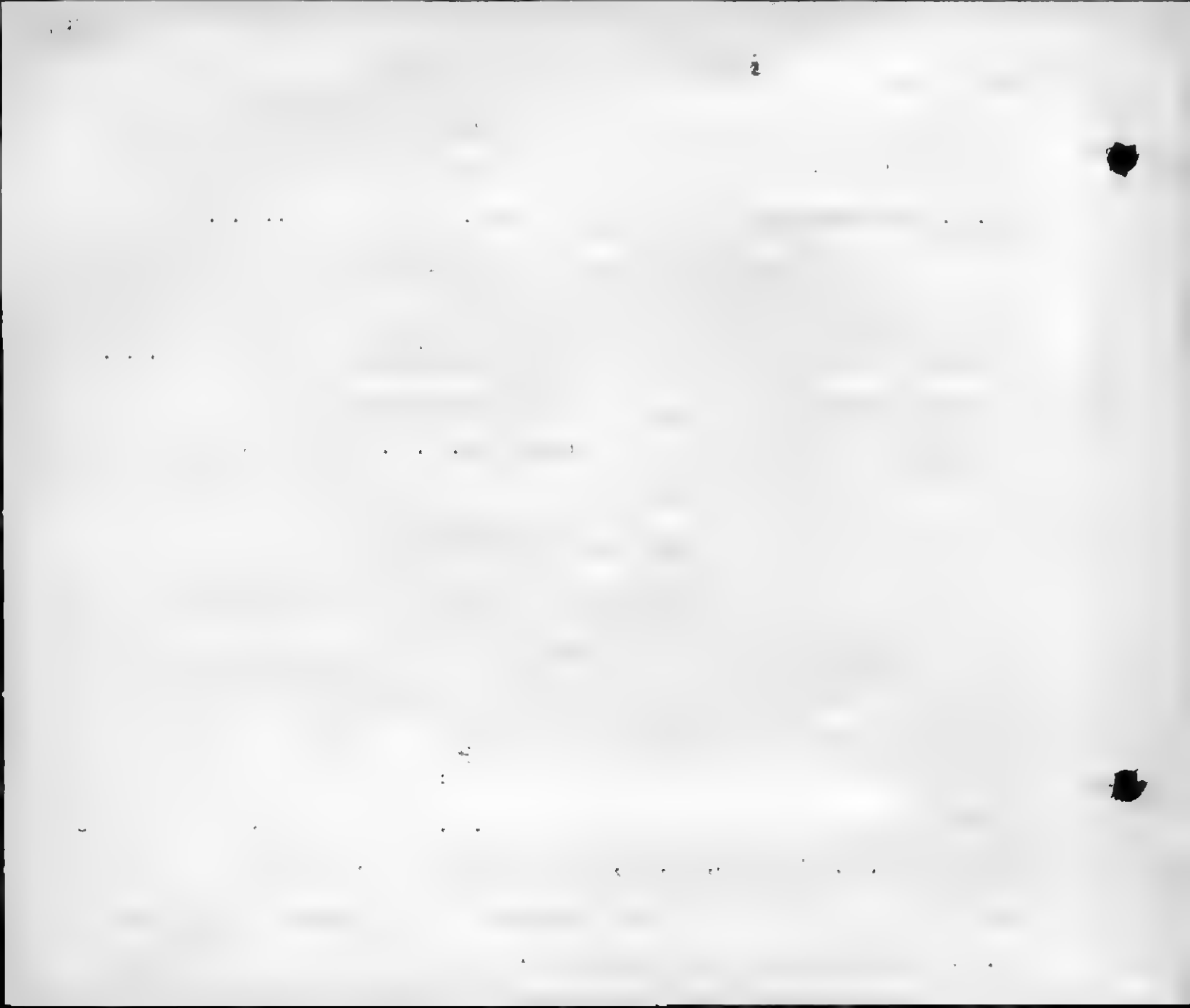
## 5758 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>161 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		47x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>Qtrs. "C", 2300 E St., N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carolyn Haller CURREY</b>		4. DATE OF DEATH Month Day Year <b>May 12 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-29-73</b>
9. AGE (In years lost birthday) yrs <b>86</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Theodore Haller</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Poter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>(SINL) Adm. W. F. Boone, USN, same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 2 19 50</b> to <b>May 12 19 59</b> , that I last saw the deceased alive on <b>May 12 19 59</b> , and that death occurred at <b>5:24P M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital, NNMC 5-13-59</b>			
ACTUAL SIGNATURE <b>F. H. O'Connell</b>		M.D. <b>U. S. Naval Hospital, NNMC</b>	
PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, LT, MC, USN</b>		<b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial - Shreveport</b>		22b. DATE THEREOF <b>5-13-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Shreveport Louisiana</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 5712 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hospital</u>				e. STREET ADDRESS <u>La Salle Road.</u>			
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>Augusta</u> Last <u>DANT</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb + 13, 1878</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sholemuker</u>				14. MOTHER'S MAIDEN NAME <u>Margaret L. Emmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Dorothy B. Granadas, 804 Kenilworth T. Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardiovascular disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 22, 1959</u> , to <u>May 31, 1959</u> , that I last saw the deceased alive on <u>May 31, 1959</u> , and that death occurred at <u>7:00 PM</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Daisy N. Carlton</u>				ADDRESS (Street, city or town, state) <u>940-25th St, 7. W. Waco, TX 76798</u>			
DATE SIGNED <u>6/3/1959</u>							
PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 3, 1959</u>		<u>London Park Cemetery</u>		<u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll Park Rd</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 F11. 10-5 6-17-55 et

## CERTIFICATE OF DEATH

05737

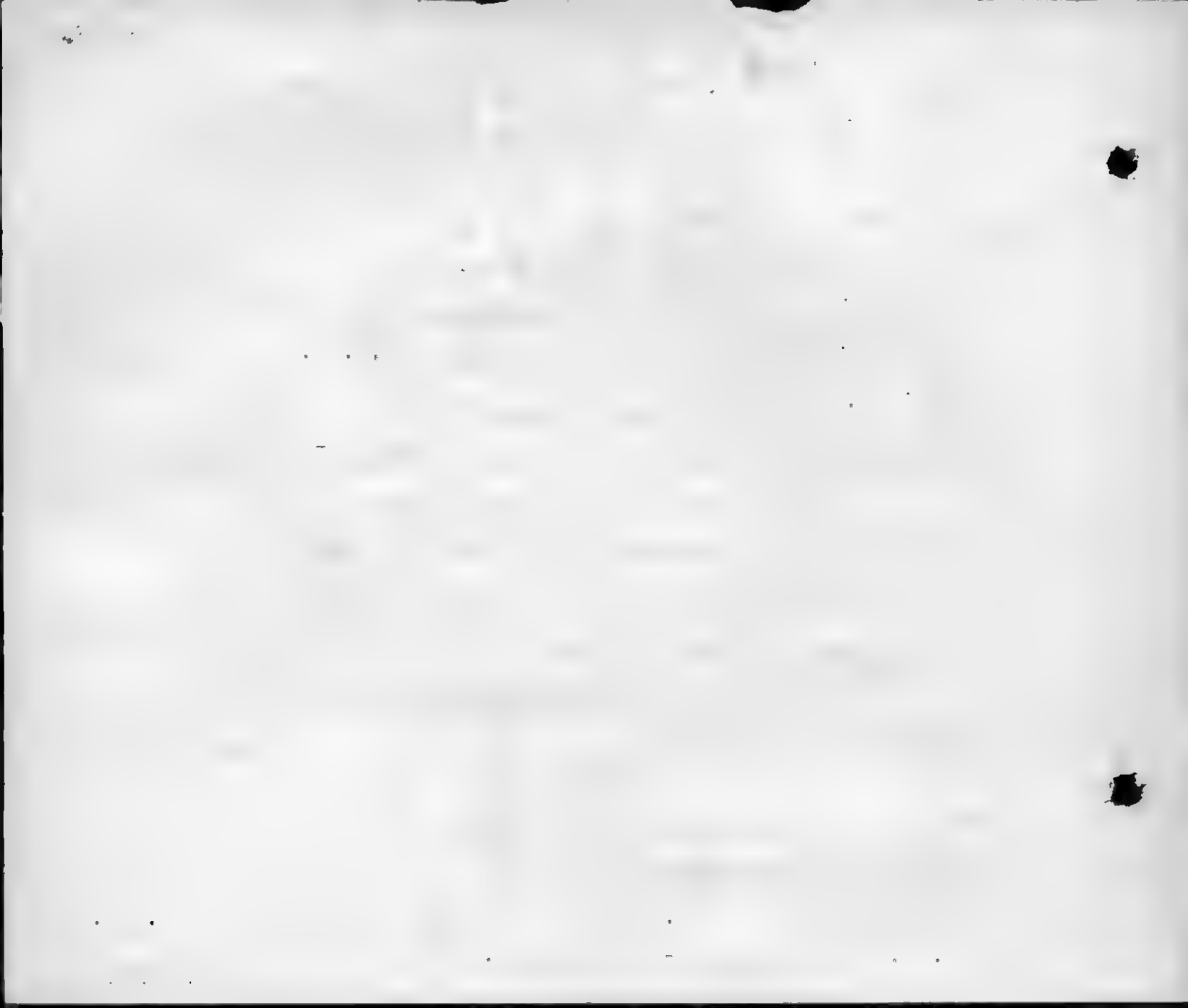
Reg. Dist. No.

5759

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> Washington, D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Le Beau Gardens</u>		d. STREET ADDRESS <u>Barker &amp; Forest Glen</u>	
3. NAME OF DECEASED (Type or print) <u>Henrietta A. Darneille</u>		4. DATE OF DEATH <u>May 5 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 10-1877</u> 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk (Govt)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Benjamin J. Darneille</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Addison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Nursing</u>		Address <u>Next Home Records- same as #2</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>on ship</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 12, 1959</u> to <u>May 5, 1959</u> , that I last saw the deceased alive on <u>May 4, 1959</u> , and that death occurred at <u>5:30</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. B. Thibodeau</u> M.D.		ADDRESS (Street, city or town, state) <u>Box 657 Silver Spring Md</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>R. B. THIBODEAU</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>5/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The S. H. Hines Company -Washington, D.C</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 6 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

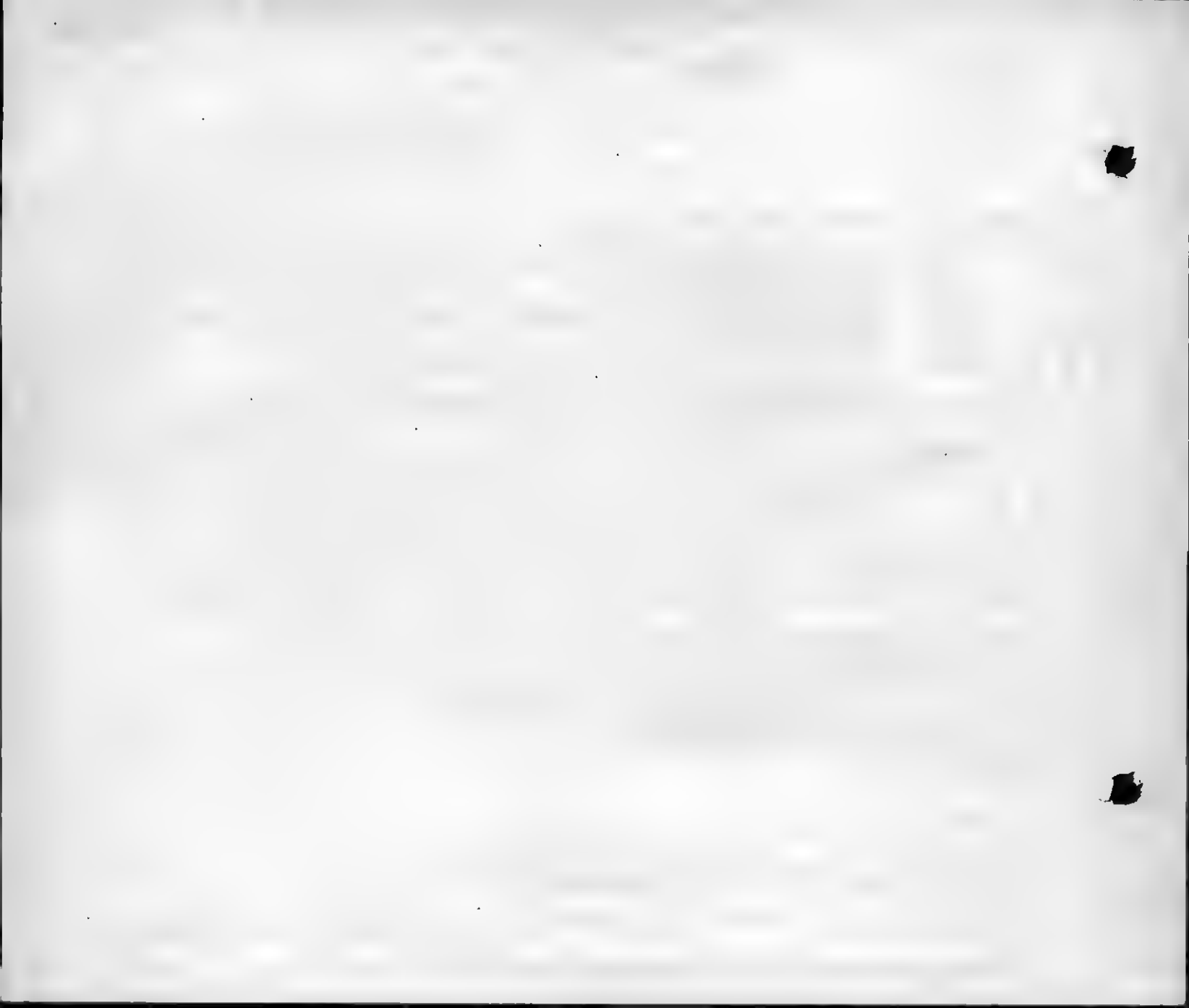
CERTIFICATE OF DEATH

Reg. Dist. No.

05738

5760

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) FOR INSTITUTION <u>Congressional Manor San.</u>		d. STREET ADDRESS <u>15212 Augusta St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>E</u> Last <u>Lellinger</u>		4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Front Royal, Va.</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>George W. Lellinger</u>		14. MOTHER'S MAIDEN NAME <u>Alvaretta Rogers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>None</u>	
17. INFORMANT <u>Mrs. Evelyn D. Beall</u>		Address <u>15212 Augusta St. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X Anemia, terminal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Leptothorax, advanced</u> (c) <u>Arteriosclerosis, general, severe</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 wks.</u> <u>1 yr.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thromboses, multiple</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1949</u> to <u>May 22, 1959</u> , that I last saw the deceased alive on <u>May 21, 1959</u> , and that death occurred at <u>1145 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>3921 Ingomar St. Wash 15 DC</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		DATE SIGNED <u>5/23/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lellinger Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Waterlick Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home, Wash DC</u>		24a. REC'D BY REGISTRAR <u>May 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>William A. Thomas</u>



## 5761 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington</u> b. COUNTY <u>Stevens</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chewelah</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9612 Glencrest Lane</u>		d. STREET ADDRESS <u>111 W. Colville Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Della</u> First <u>E</u> Middle <u>Danlap</u> Last		4. DATE OF DEATH: <u>May</u> Month <u>29</u> Day <u>1959</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/78</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR: Months <u>3</u> Days <u>19</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Montano</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Henry Evans</u>		14. MOTHER'S MAIDEN NAME <u>Clara Peters.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, <u>no</u> ) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>333-05-08970</u>	
17. INFORMANT <u>Hellen Peters</u>		Address <u>9612 Glencrest Ln</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY: Hour <u>None</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 12, 1959</u> to <u>present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 25, 1959</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhau</u> M.D.		ADDRESS (Street, city or town, state) <u>8805 Conn Ave</u> DATE SIGNED <u>5/29/59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAU</u>		<u>CHEXY CHASE MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-1-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5762 CERTIFICATE OF DEATH

05740

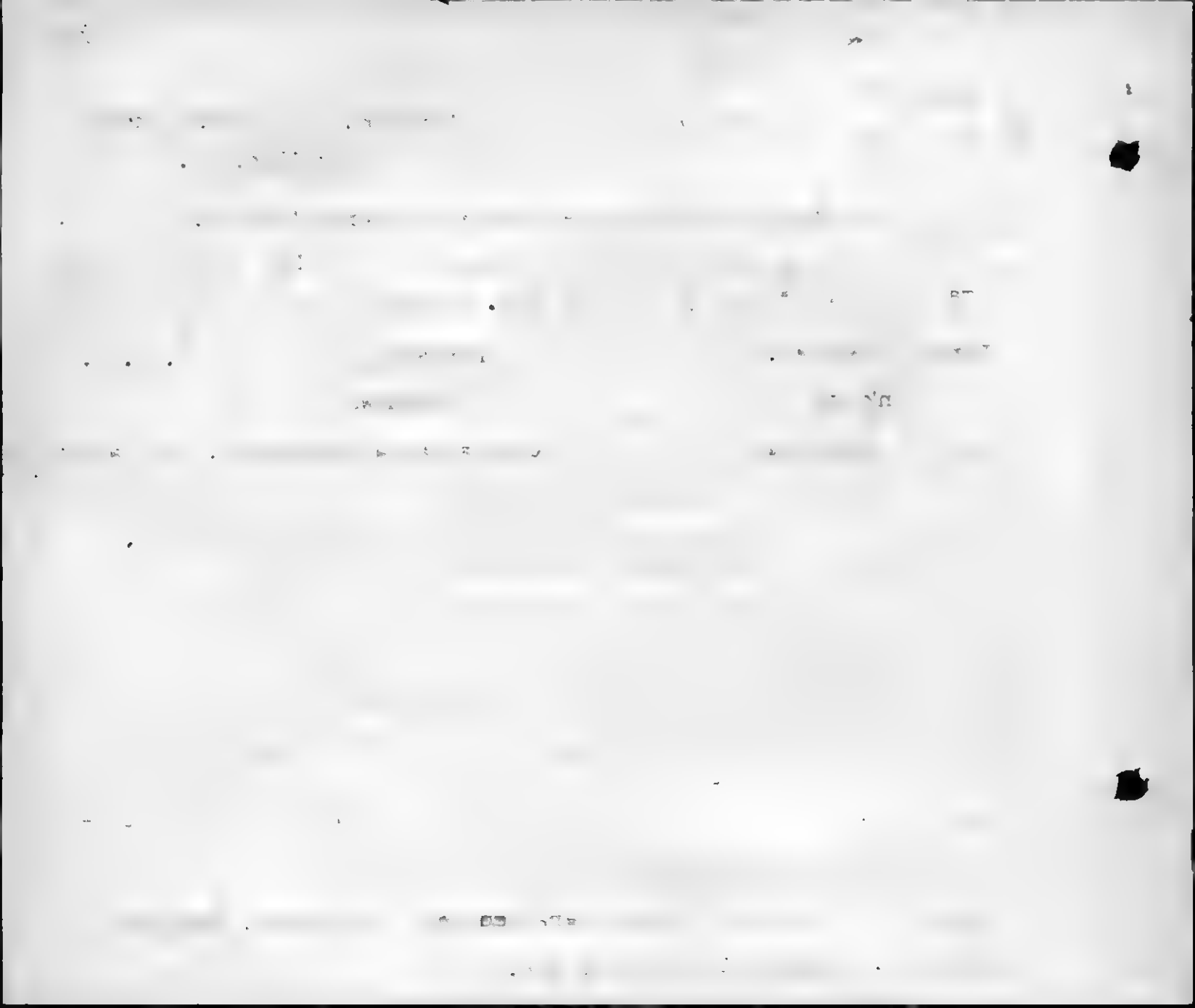
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery, MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route 32 Clarksville, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Christian Eichen</b>		4. DATE OF DEATH Month Day Year <b>May 8 1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1895</b>
9. AGE (In years last birthday) <b>63</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber (self em.)</b>	11. BIRTHPLACE (State or foreign country) <b>Hungary</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes World War I</b>	
16. SOCIAL SECURITY NO. <b>Victoria Maria Neduhall Rt. 32 Clarksville, Md.</b>		17. INFORMANT <b>Victoria Maria Neduhall Rt. 32 Clarksville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of the stomach with } DUE TO abdominal metastases</b> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 10, 1958, to May 8, 1959</b> , that I last saw the deceased alive on <b>May 8, 1959</b> , and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Charles S. Whitaker</b>		ADDRESS (Street, city or town, state) <b>Clarksville, Maryland</b>	
DATE SIGNED <b>5-8-59</b>		M.D. <b>Charles S. Whitaker, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave.</b>	
24a. REC'D BY REGISTRAR <b>MAY 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kerner</b>	

MEDICAL CERTIFICATION

VS A15 (4)  
15M 10/57

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5763

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05741

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Yorktown Village 1 hr. 15 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47x</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5104 Washington Dr. Wash. DC</u>		d. STREET ADDRESS <u>4100 W ST. N.W. apt 411</u>	
3. NAME OF DECEASED (Type or print) <u>Tairo Andrew Erickson</u>		4. DATE OF DEATH <u>May 1 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-27-1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. FUNDER 1 YEAR <u>Months</u> Days <u>Hours</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Security Officer</u>	
11. BIRTHPLACE (State or foreign country) <u>Mich</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Auro Erickson (wife)</u>		Address <u>Stem 2</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (c), stating the underlying cause last. <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brochart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brochart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Spec. Ty) <u>BURIAL</u>		22b. DATE THEREOF <u>5/4/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>THATL MEMORIAL PARK</u>		22d. LOCATION (City, town, or county) (State) <u>Fairfax County Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler's Sons Inc.</u>		24a. REC'D BY REGISTRAR <u>1756 Penna. Ave. N.W.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE <u>MAY 5 '59</u>	



## 5764 CERTIFICATE OF DEATH

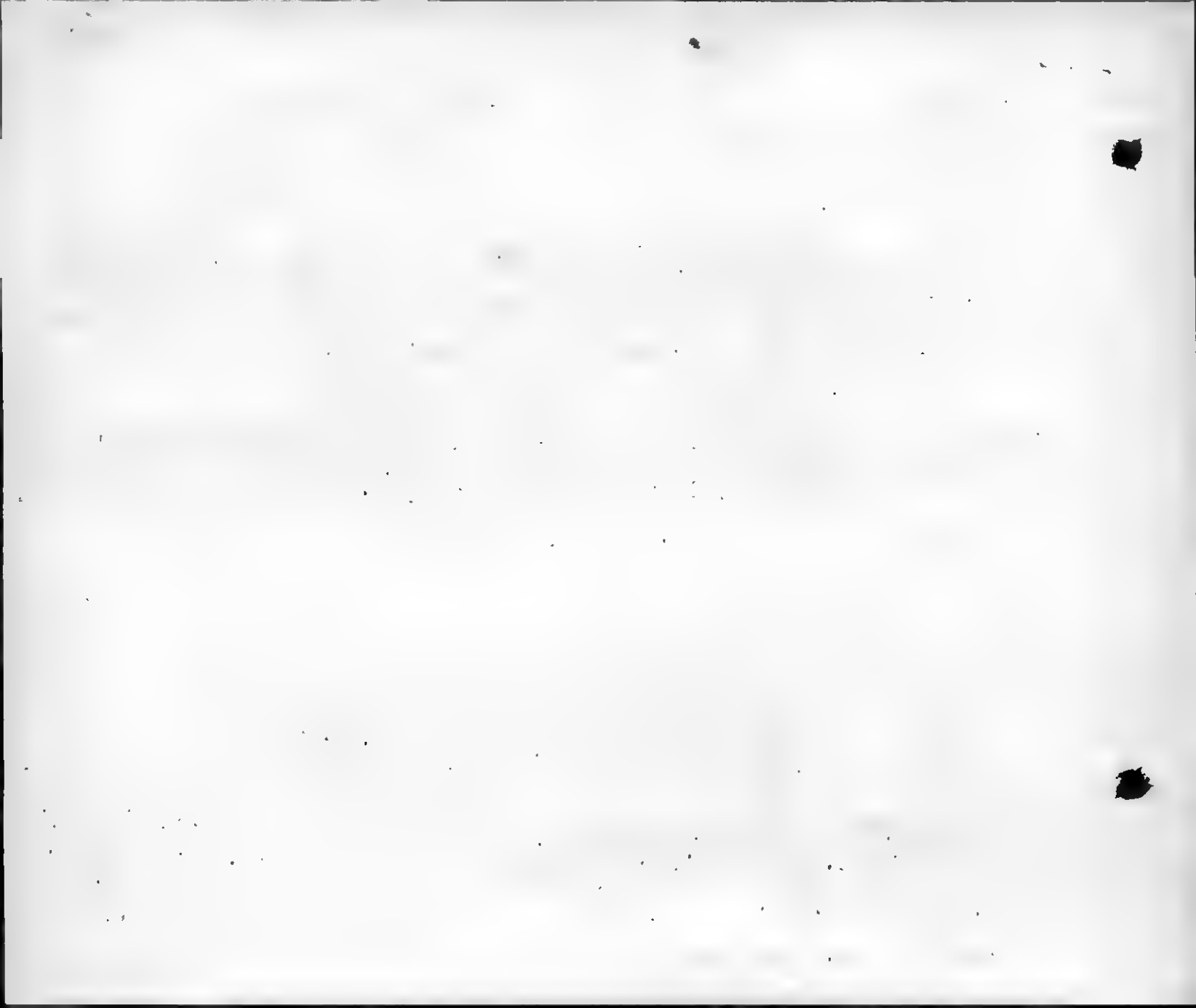
Reg. Dist. No.

05742

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland, Montgomery</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4901 Rugby Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SADIE I. FEESER</b>		4. DATE OF DEATH Month Day Year <b>May 21, 1959</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1879</b>
9. AGE (In years last birthday) yrs <b>79</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>10 3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Brooklyn, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown (Maneely)</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>	
17. INFORMANT <b>Curtis S. Feeser - Item #2-husband</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> 231X DUE TO <b>Cerebral arteriosclerosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Several weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 52 to May 21, 59</b> , that I last saw the deceased alive on <b>May 20, 59</b> , and that death occurred at <b>9:35 M.</b> from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <b>George A. Pumphrey</b> M.D.		104 Chevy Chase Drive, 5/21/59	
PHYSICIAN'S NAME (Type) <b>George A. Pumphrey, M.D.</b>		<b>15, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-25-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 25 59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Faus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



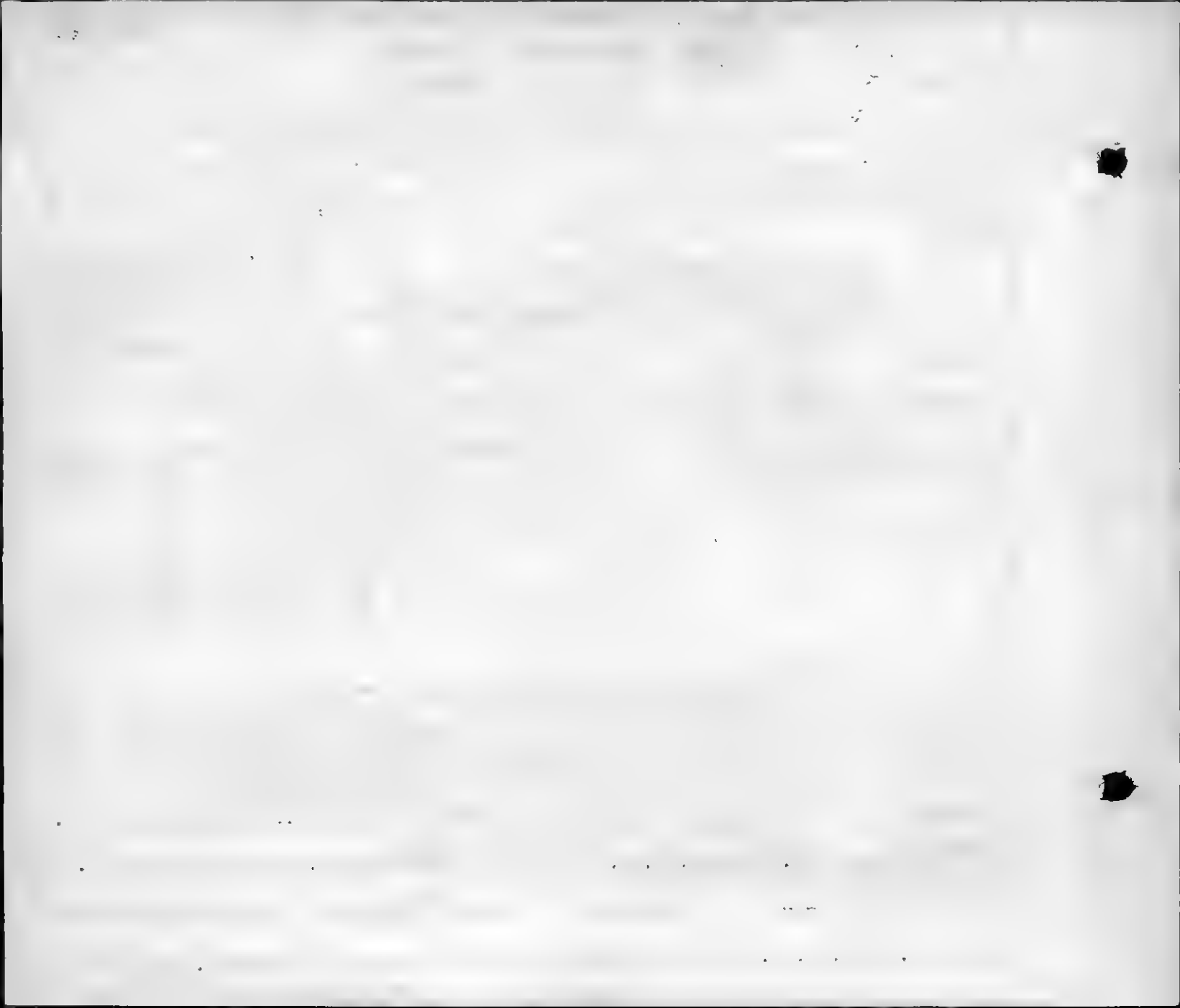
## 5713 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park, 161</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>				d. STREET ADDRESS <b>7423 Aspen Court,</b>			
3. NAME OF DECEASED (Type or print) First <b>Fenn</b> Middle <b>Fenn</b> Last <b>Fenn</b>				4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 59</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 5, 1959</b>	
9. AGE (In years last birthday) yrs. <b>6</b>		IF UNDER 1 YEAR: Months <b>6</b> Days <b>55</b>		IF UNDER 24 HRS. <b>55</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>America</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Richard Lee Fenn</b>				14. MOTHER'S MAIDEN NAME <b>Joan Rebecca Witteman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>father</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia from trauma</b> <b>no. 5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Blunt force</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Winston E. Cochran</b> M.D.				927 Pershing Dr., Silver Spring, Md.			
PHYSICIAN'S NAME (Type) <b>Winston E. Cochran, M.D.</b>				927 Pershing Dr., Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>5-5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital Takoma Park, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M.D.</b>				ADDRESS <b>Washington Sanitarium and Hospital, Takoma Park, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hare</b>			

MAY 7 '59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





5714

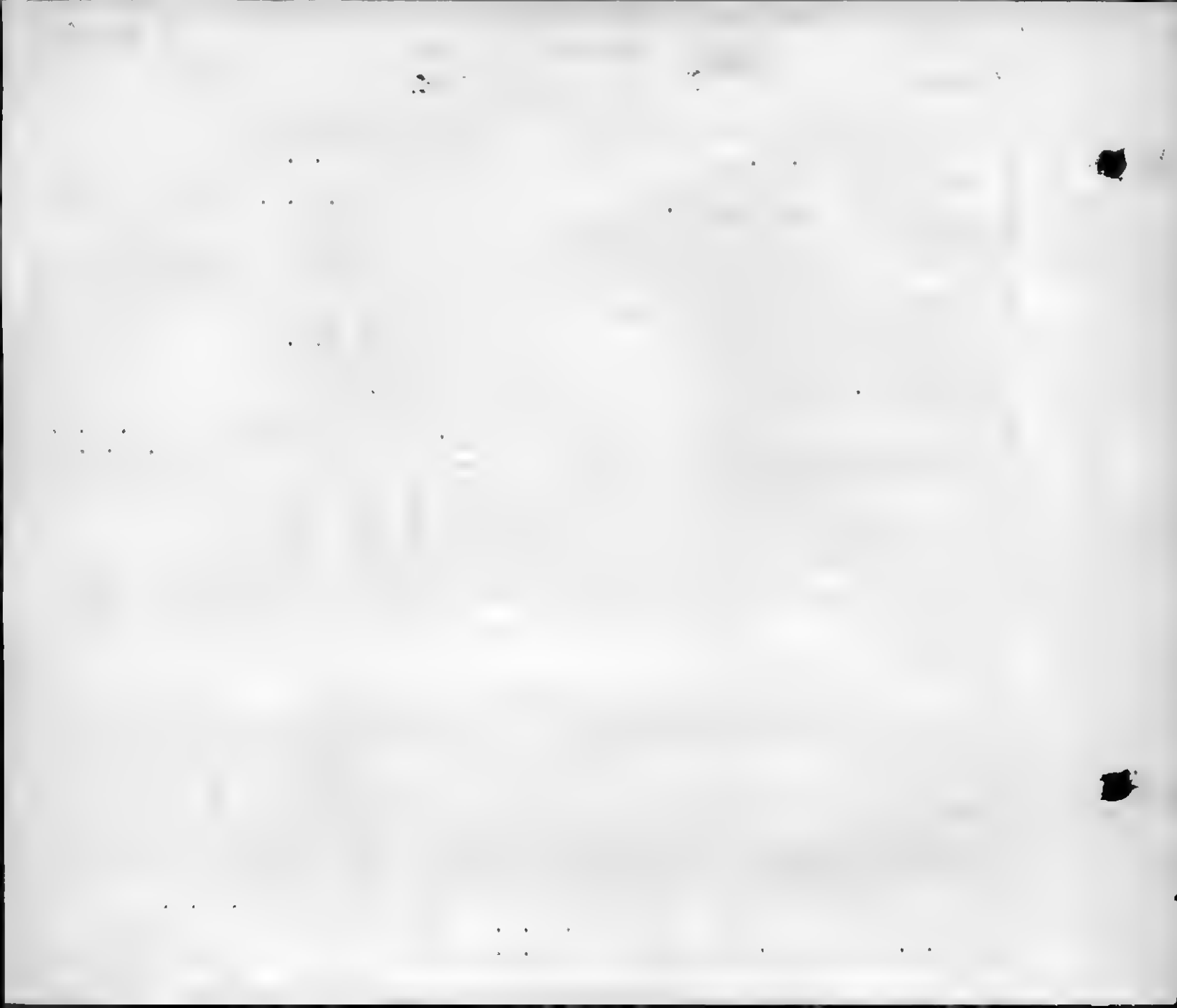
## CERTIFICATE OF DEATH

Reg. Dist. No.

05744

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park, Md.</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Full Hill Rest Home</b> <b>207 Hudson Ave.</b>				d. STREET ADDRESS <b>3900 14th St. N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Jane</b> Last <b>Fischer</b>				4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>19 59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>2/19/82</b>	
9. AGE (In years last birthday) <b>77 yrs</b>		IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>		IF UNDER 24 HRS Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>William H. Forrest</b>				14. MOTHER'S MAIDEN NAME <b>Carrie M. Sauers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <b>George A. Fischer</b>				Address <b>2714 31st St. S.E. Washington, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>180x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Generalized Arteriosclerosis</b> (c) <b>Hypertension with thickening</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>1 year</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>2:30</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Takoma Park</b>	
20f. (City or town) <b>Takoma Park</b>				20g. (County) <b>Montgomery</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>January, 1959</b> to <b>April 30<sup>th</sup>, 1959</b> that I last saw the deceased alive on <b>April 30, 1959</b> and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lysle Williams</b>				ADDRESS (Street, city or town, state) <b>8700 Calverville Rd Silver Spring Md 20910</b>			
DATE SIGNED <b>May 1, 1959</b>							
PHYSICIAN'S NAME (Type) <b>Lysle Williams M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. Washington 9, D.C.</b>				24a. REC'D BY REGISTRAR <b>MAY 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5763

## CERTIFICATE OF DEATH

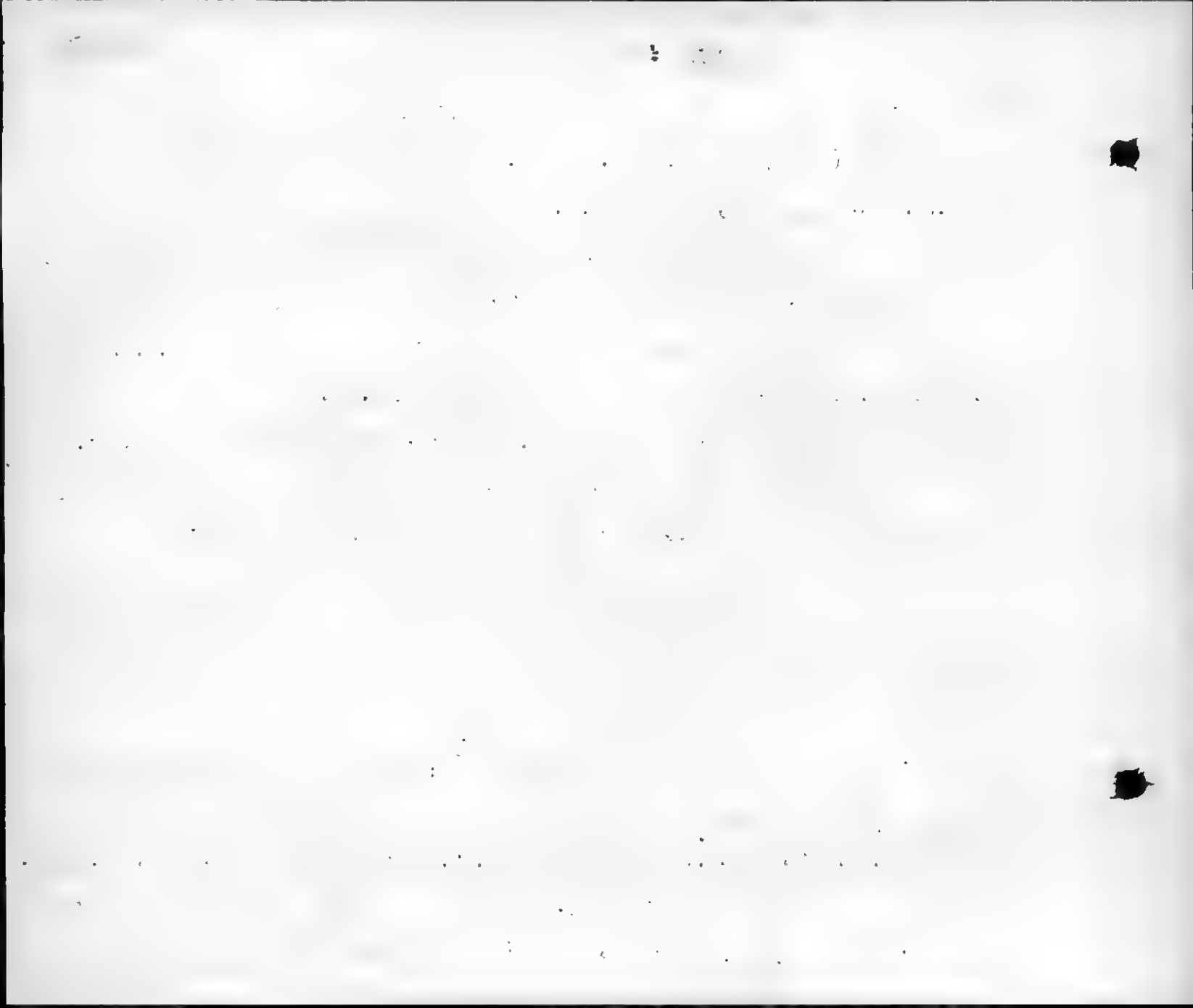
Reg. Dist. No. 05746

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Loudoun</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>19 hrs. 50 min.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Chester</b> Middle <b>Lawrence</b> Last <b>Fordney</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6 COLOR OR RACE <b>Caucasian</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1892</b>
9 AGE (In years last birthday) yrs. <b>66</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USMC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USMC</b>	11. BIRTHPLACE (State or foreign country) <b>Michigan</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Joseph Warren Fordney</b>		14. MOTHER'S MAIDEN NAME <b>Kathryn Haaren</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16 SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Dorothy Fordney (Wife)</b>		Address <b>Hamilton, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertensive cardiovascular disease</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 25</b> , 19 <b>59</b> to <b>May 26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 26</b> , 19 <b>59</b> , and that death occurred at <b>6:00A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>F. J. LINEHAN JR.</b> M.D.			
PHYSICIAN'S NAME (Type) <b>F. J. LINEHAN JR., LCDR MC USN</b>		U. S. Naval Hospital, Bethesda, Maryland.	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-29-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Muse and Reed</b>		24a. REC'D BY REGISTRAR <b>JUN 1 '59</b>	
ADDRESS <b>Leesburg, Virginia</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/58



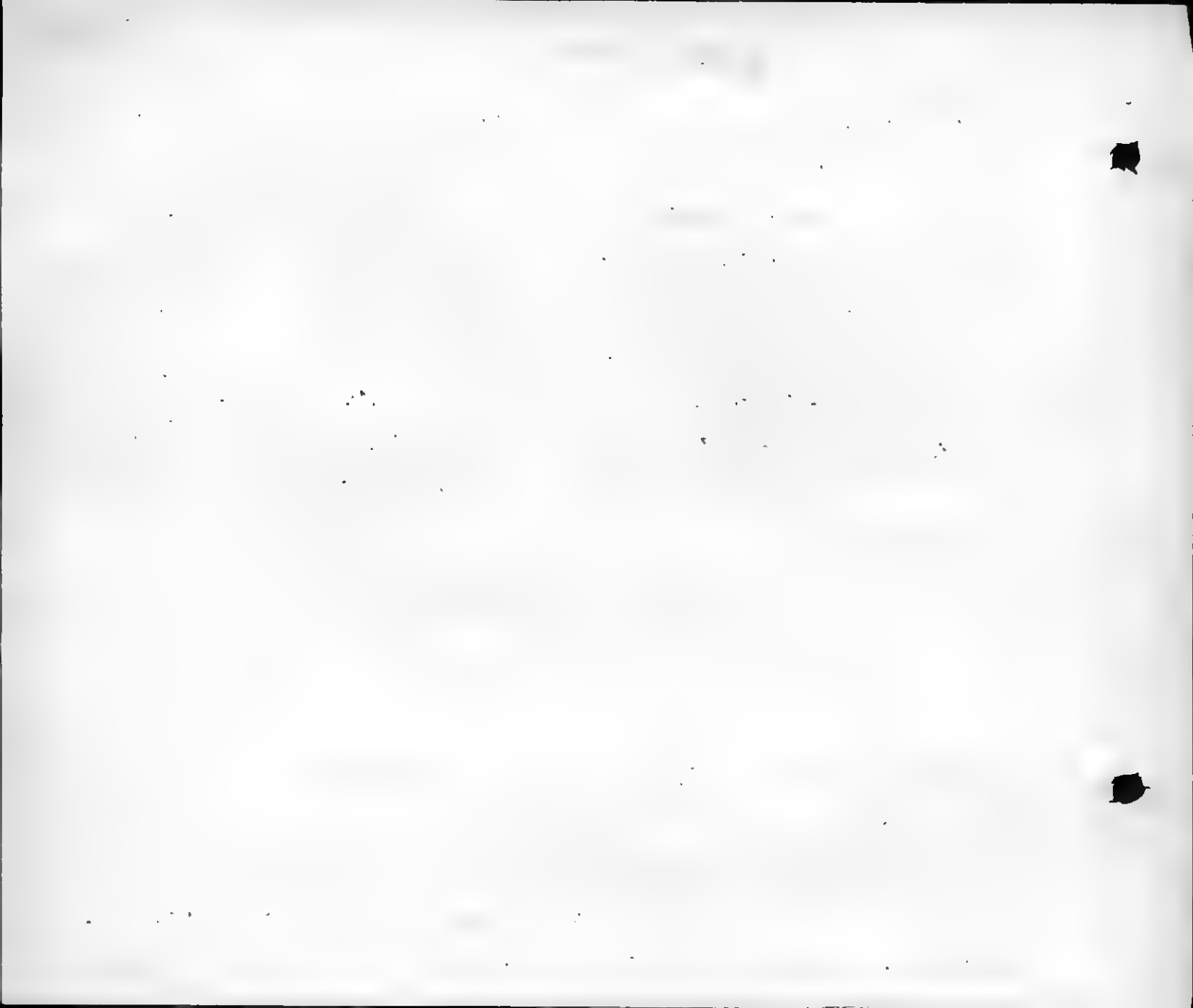
## 5766 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. STREET ADDRESS <u>CIRCLE DRIVE, GLEN HILLS</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ISABEL LIVINGSTONE FOX</u>		4. DATE OF DEATH Month Day Year <u>5 5 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/22/1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. <u>1 13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WALTER WOLSTENHOLM</u>		14. MOTHER'S MAIDEN NAME <u>SARAH BAQSHAW - WOLSTENHOLM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-22-8074</u>	
17. INFORMANT <u>CLIFFORD LIVINGSTONE</u>		Address <u>1501 S. 28th ST. APT. 6 ARLINGTON, VA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma c Metastatic</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1958</u> to <u>present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3 May 1959</u> , and that death occurred at <u>12:15 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SMAY 59</u> DATE SIGNED ACTUAL SIGNATURE <u>Marvin Wilson</u> M.D. <u>809 Viers mill Rd</u> PHYSICIAN'S NAME (Type) <u>MARVIN M. GIBSON</u> <u>Rockville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/8/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda 14, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 7 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05748
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>5767</b> <u>SENECA MD.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY					
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>POTOMAC RIVER</u>					c. LENGTH OF STAY IN 1b <u>83x-3</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>2206 Cherri Drive</u>					
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>E</u> Middle <u>Froendt</u> Last					4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1959</u>					
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 30, 1929</u>		9. AGE (In years last birthday) <u>30</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U S Army</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>unk</u>					14. MOTHER'S MAIDEN NAME <u>unk</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> <u>850x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Motor boat he was driving swamped in mid river, and he was unable to swim to shore</u>								
20c. TIME OF INJURY Month, Day, Year <u>7:30</u> a. m. <u>May 2, 59</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Potomac River</u>		20f. (City or town) <u>Seneca</u>		20g. (County) <u>Montg.</u>		
20h. (State) <u>Md.</u>										
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>John B. Ball</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
NAME (Type) <u>John G Ball</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7 May 1959</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>			22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u>					ADDRESS <u>816 H ST. N.E. WASHDC.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	





## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

5768

## CERTIFICATE OF DEATH

05749

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Germantown</u> 45 years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rural</u>			
3. NAME OF DECEASED (Type or print) <u>Cornelius</u> First <u>Martin</u> Middle <u>Finney</u> Last				4. DATE OF DEATH <u>May - 25 - 1959</u> Month - Day - Year			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT-23-1872</u>	9. AGE (In years last birthday) <u>86</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BVC Rail Road</u>		11. BIRTHPLACE (State or foreign country) <u>London Co., Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Idella Reed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>905-07-7544</u>		17. INFORMANT <u>Ruth V. Finney, Rural Germantown, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral accidents (405)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>mental deterioration</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May - 24 - 1959</u> , to <u>May - 25 - 1959</u> , that I last saw the deceased alive on <u>May - 24 - 1959</u> , and that death occurred at <u>5:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William C. Miller</u>				M.D. <u>7 - Brooks Ave., Gaithersburg, Md</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>				<u>Gaithersburg, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5.28.59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose Cemetery</u>		22d. LOCATION (City, town, or county) <u>Gaithersburg, Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Miller</u> ADDRESS <u>316 E. Diamond Ave. Gaithersburg, Md.</u>				24a. REC'D BY REGISTRAR <u>W. C. Miller</u> DATE <u>JUN 1 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. French</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first part of the report is a general  
description of the area. It is a large area  
of land, mostly flat, with some hills in the  
north. The climate is hot and dry, with  
high temperatures and low rainfall. The  
population is small, and the economy is  
based on agriculture. The main crops are  
wheat and barley. There are some  
livestock, but they are not very numerous.  
The land is mostly owned by a few  
large landowners. The rest of the population  
is poor and has no land. The government  
is weak and corrupt. The people are  
poor and have no money. The land is  
mostly owned by a few large landowners.  
The rest of the population is poor and has  
no land. The government is weak and  
corrupt. The people are poor and have  
no money.

The second part of the report is a general  
description of the area. It is a large area  
of land, mostly flat, with some hills in the  
north. The climate is hot and dry, with  
high temperatures and low rainfall. The  
population is small, and the economy is  
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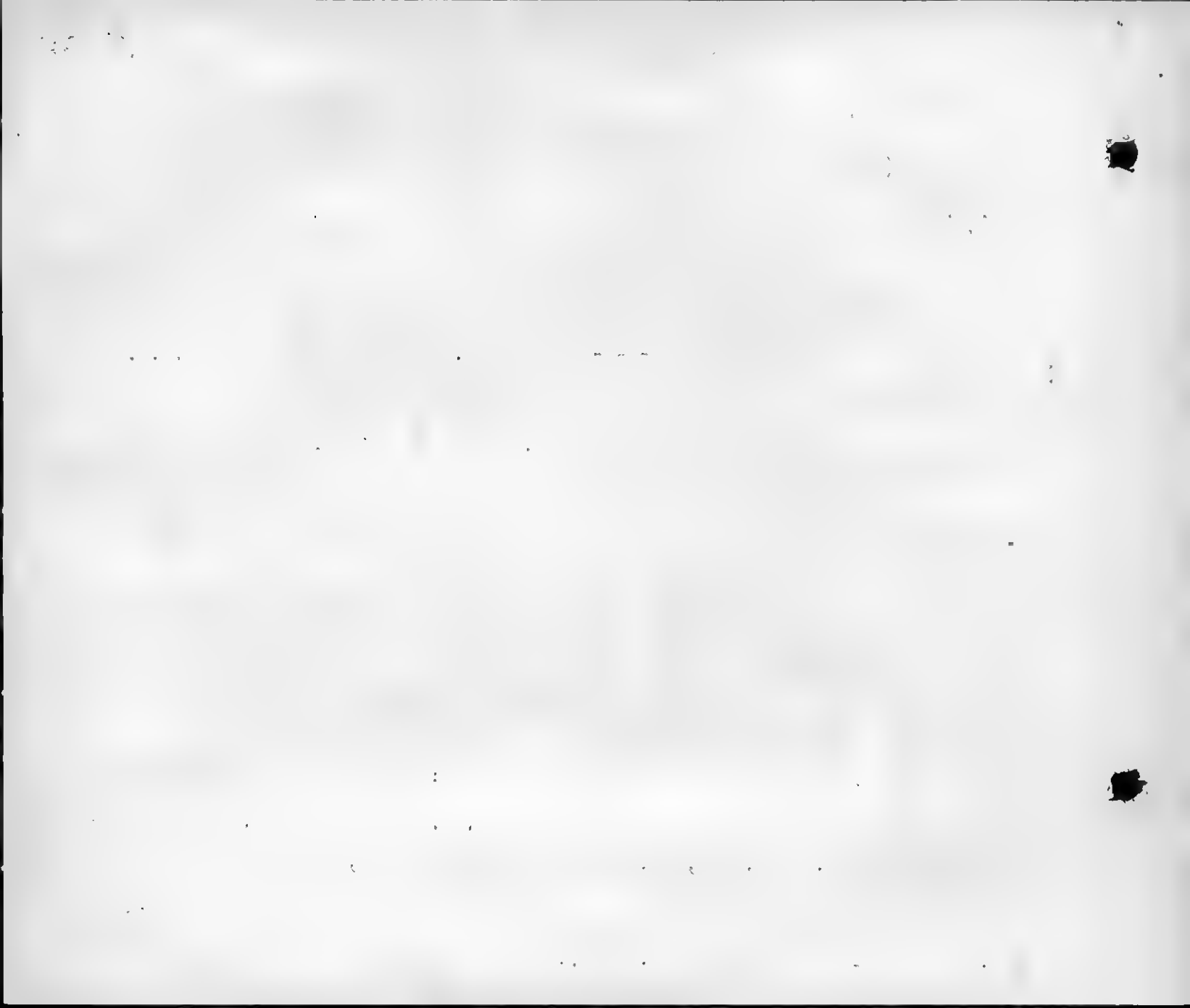
William C. Miller  
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high temperatures and low rainfall. The  
population is small, and the economy is  
based on agriculture. The main crops are  
wheat and barley. There are some  
livestock, but they are not very numerous.  
The land is mostly owned by a few  
large landowners. The rest of the population  
is poor and has no land. The government  
is weak and corrupt. The people are  
poor and have no money. The land is  
mostly owned by a few large landowners.  
The rest of the population is poor and has  
no land. The government is weak and  
corrupt. The people are poor and have  
no money.

## 5769 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>936 Madison Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) First Middle Last <b>Roscoe Flabious GRADY</b>		4. DATE OF DEATH Month Day Year <b>May 15 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-22-91</b>
9. AGE (In years last birthday) <b>68</b> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>No. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jones GRADY</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane (Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO <b>579 05 9631</b>	
17. INFORMANT Address <b>Mrs. Amy Grady (Wife), same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO (c) <b>But Op Appendicitis with perforation</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>1 wk</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 14 1959</b> to <b>May 15 1959</b> , that I last saw the deceased alive on <b>May 15 1959</b> , and that death occurred at <b>9:50P M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Troy</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital, NMC 5-16-59</b>	
PHYSICIAN'S NAME (Type) <b>John W. TROY, CDR, MC, USN</b>		<b>Bethesda 14, Maryland</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-20-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chmaber's, 1400 Chapin St., N.W., Wash, DC</b>		24a. REC'D BY REGISTRAR <b>MAY 19 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Quiting &amp; House</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5770

## CERTIFICATE OF DEATH

05751

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8324 - 16th STREET</u>		d. STREET ADDRESS <u>18324 - 16th STREET.</u>	
3. NAME OF DECEASED (Type or print) <u>MILDRED ROWLEY GRAHAM</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 28, 1904</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FISCAL CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. OF JUSTICE</u>	
11. BIRTHPLACE (State or foreign country) <u>ELMIRA, NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>TIMOTHY ROWLEY</u>		14. MOTHER'S MAIDEN NAME <u>MABLE HORTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-09-6965</u>	
17. INFORMANT <u>JOHN W. GRAHAM,</u>		Address <u>8324 16th ST. S.S. MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chronic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>30 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Tele</u> , 19 <u>58</u> to <u>May 13, 1959</u> , that I last saw the deceased alive on <u>May 9, 1959</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. F. Kreuzburg</u>		ADDRESS (Street, city or town, state) <u>7852 16th St NW</u>	
PHYSICIAN'S NAME (Type) <u>Wash 12 DC</u>		DATE SIGNED <u>5/13/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 18, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Canal St NW</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 15 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5771

CERTIFICATE OF DEATH

05752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1210 Highland Drive</b>		d. STREET ADDRESS <b>1210 Highland Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Mathew M</b> Last <b>Gullick</b>		4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/14/1887</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Joseph Gullick</b>		14. MOTHER'S MAIDEN NAME <b>Susan Kushner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W.1</b>	
17. INFORMANT <b>Milton P. Birthright-8712 Colesville Rd.</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 5, 1956</b> to <b>May 2, 1957</b> , that I last saw the deceased alive on <b>May 2, 1957</b> , and that death occurred at <b>11 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7852 16th St. N.W. Wash. D.C.</b> DATE SIGNED <b>5/2/59</b>			
ACTUAL SIGNATURE <b>H F Kreuzburg</b>		M.D. <b>Wash. D.C.</b>	
PHYSICIAN'S NAME (Type) <b>H F Kreuzburg</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>5/6/59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.-2901 14th St., N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 5 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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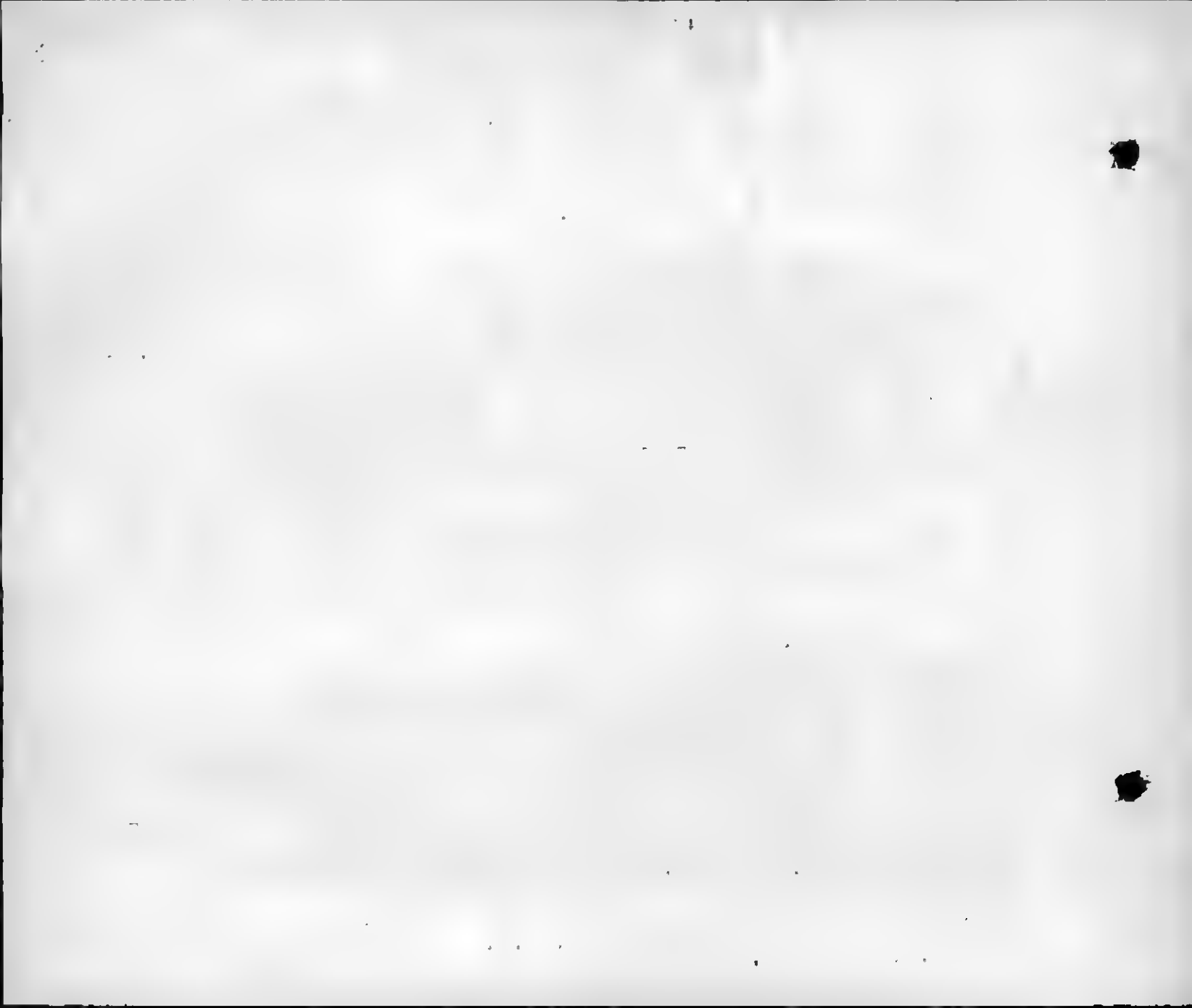
## 5772 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>77 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>General Delivery</u>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>James</u> Last <u>Hager</u>				4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1907</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motorman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mining</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jim Hager</u>				14. MOTHER'S MAIDEN NAME <u>Cora Kenser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>236-03-9539</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>420.1</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u> <u>Years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Lymphocytic Leukemia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from <u>March 13</u> , 19 <u>59</u> , to <u>May 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 29</u> , 19 <u>59</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>5-30-59</u> <u>The National Institutes of Health</u> <u>Bethesda 14, Maryland</u>							
ACTUAL SIGNATURE <u>Nathan S. Taylor</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Nathan S. Taylor, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>5/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Logan, West Virginia</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> <u>2901 14th St. N.W.</u> <u>Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



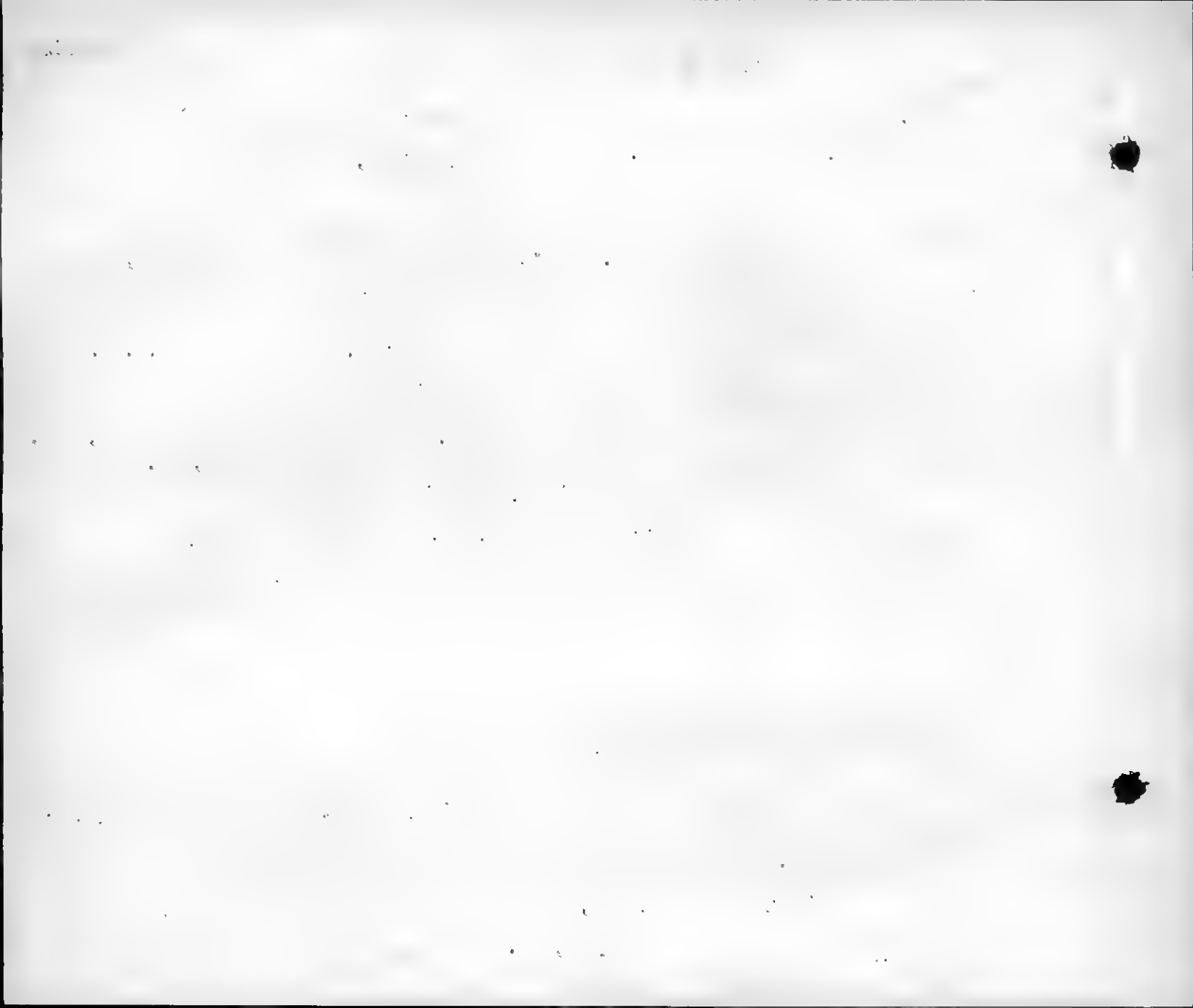
## 5773 CERTIFICATE OF DEATH

Reg. Dist. No. 05754

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Poolesville</b> c. LENGTH OF STAY IN life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Poolesville, (Rural)</b> d. STREET ADDRESS <b>/</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>W.</b> Last <b>HAMILTON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>19 59</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1886</b> 9. AGE (In years last birthday) <b>73</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Wallace Hamilton</b>		14. MOTHER'S MAIDEN NAME <b>Alice Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Florence Hebron</b>		Address <b>4507 Rhode Island, Ave. Brentwood, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>Arterio Sclerosis, Generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4 years</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>54</b> , to <b>8 May</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8 May</b> , 19 <b>59</b> , and that death occurred at <b>Md.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b> DATE SIGNED <b>8 May 59</b> ACTUAL SIGNATURE <b>Gordon M. Smith</b> M.D. PHYSICIAN'S NAME (Type) <b>Gordon M. Smith</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Elijah,</b>		22d. LOCATION (City, town, or county) (State) <b>Poolesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sworden</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 14 '59</b>	
ADDRESS <b>Rockville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5774

## CERTIFICATE OF DEATH

05755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>43 AM days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Frederica</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean Drive Manor</u> d. STREET ADDRESS <u>Ocean Drive Manor</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Della Angeline Harden</u>		4. DATE OF DEATH Month Day Year <u>May 29, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 31, 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min <u>61</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Midwife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Enoch Ferrell</u>		14. MOTHER'S MAIDEN NAME <u>Florence Neuzum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion + Atelectasis</u> <u>2040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Lymphocytic Leukemia</u> DUE TO (c) <u>12-14 mos.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>2</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 16, 1959</u> , to <u>May 29, 1959</u> , that I last saw the deceased alive on <u>May 29, 1959</u> , and that death occurred at <u>11:58 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Habeeb Bacchus</u> M.D. <u>The Clinical Center</u> DATE SIGNED <u>5-30-59</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>		22b. DATE THEREOF <u>6-2-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Catawba W. Va</u>		22d. LOCATION (City, town, or county) (State) <u>Catawba W. Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A Pumphrey</u>		24a. REC'D BY REGISTRAR <u>7557 Wisc Ave Beth Md</u>	
24b. REGISTRAR'S SIGNATURE <u>June 2 '59</u>		24c. REGISTRAR'S SIGNATURE <u>Orthman E. Krasner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5775 CERTIFICATE OF DEATH

05756

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>49 days</b>		d. STREET ADDRESS <b>1000 Massachusetts Avenue, NW</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Jo</b> Last <b>Harrison</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1907</b>
9. AGE (In years last birthday) <b>51</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assistant Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Perpetual Bldg. Ass'n.</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>William M. Moran</b>		14. MOTHER'S MAIDEN NAME <b>Marion Kinter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-12-1787</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause or line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acoustic Neuroma, left</b> DUE TO <b>Chronic Pyelonephritis, bilateral</b> DUE TO <b>Bronchopneumonia, bilateral</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 years</b> <b>1-2 years</b> <b>24 hours</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 22, 1959</b> , to <b>May 10, 1959</b> , that I last saw the deceased alive on <b>May 10, 1959</b> , and that death occurred at <b>8:25 a.m.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>[Signature]</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>5/10/59</b>	
PHYSICIAN'S NAME (Type) <b>EDWARD J. LASKOWSKI, M.D.</b>		<b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/13/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		24. REC'D BY REGISTRAR DATE <b>MAY 15 '59</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kiser</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

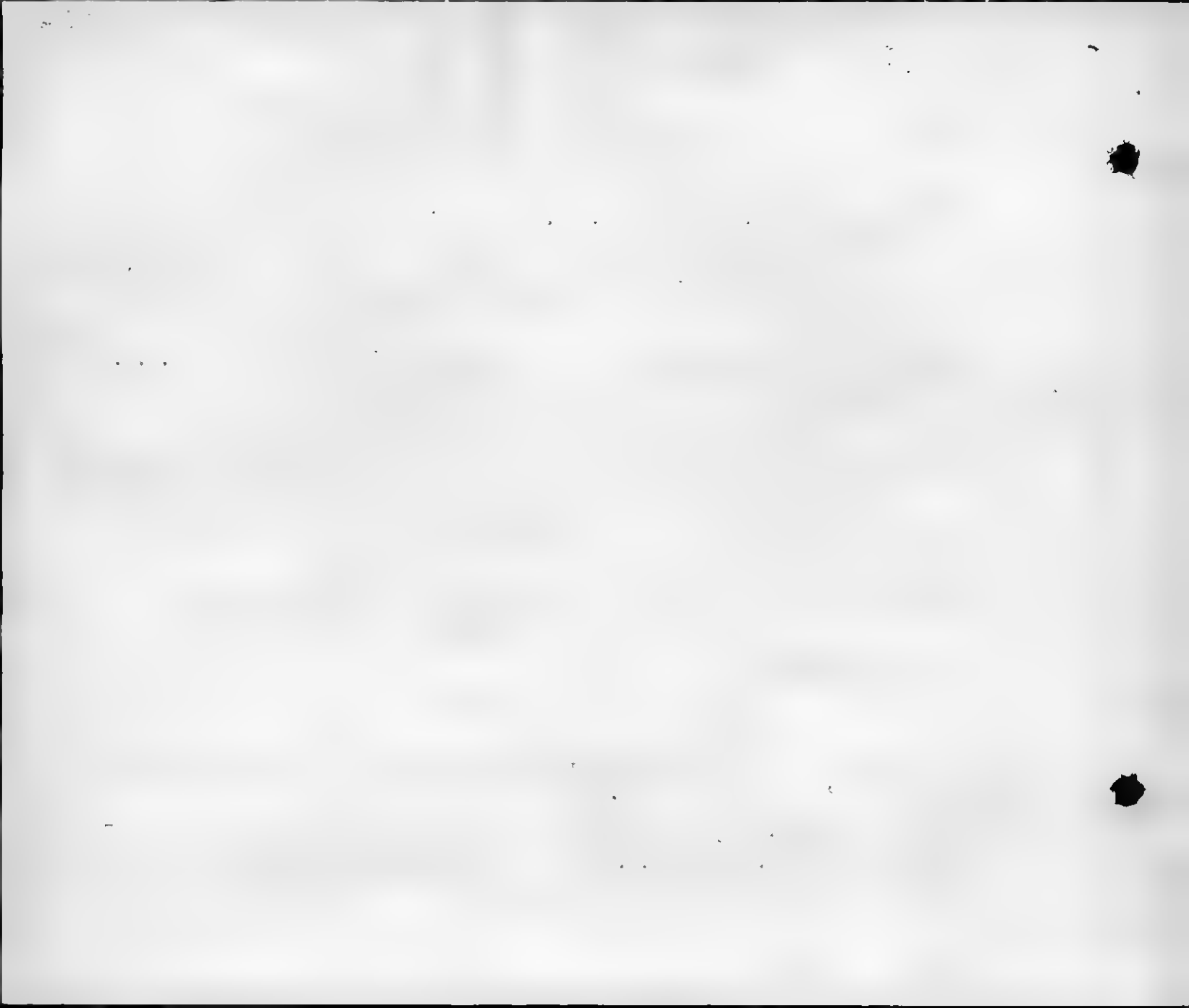
## 5776 CERTIFICATE OF DEATH

05757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>9 days</b>			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Conemaugh</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1140 William Penn Avenue</b> d. STREET ADDRESS <b>1140 William Penn Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Helen Agatha Harteis</b>			4. DATE OF DEATH Month Day Year <b>May 26, 1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 3, 1925</b>		9. AGE (In years last birthday) <b>33</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>Webster Sweeney</b>			14. MOTHER'S MAIDEN NAME <b>Agatha McGuire</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumatic heart disease -</b> DUE TO <b>probable embolization during</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>mitral commissurotomy</b> (c) <b>mitral commissurotomy</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 17, 1959</b> to <b>May 26, 1959</b> that I last saw the deceased alive on <b>May 26, 1959</b> and that death occurred at <b>12:00 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 5-26-59</b> NATIONAL INSTITUTES OF HEALTH <b>Bethesda 14, Maryland</b>					
ACTUAL SIGNATURE <b>William W. Pfaff, M.D.</b>		PHYSICIAN'S NAME (Type) <b>William W. Pfaff, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/29/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Johnstown, Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 28 1959</b>	24b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5777 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>9 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>1</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>5100 T Street, S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Edward HEINEMAN</b>			4. DATE OF DEATH Month Day Year <b>May 6 19 59</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-20-86</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Christian HEINEMAN</b>				
14. MOTHER'S MAIDEN NAME <b>Fanny EIKEE</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes 1902 - 1945</b>				
16. SOCIAL SECURITY NO. <b>579-14-6019</b>			17. INFORMANT <b>(W) Mrs. Stella Heineman, same as #2 above</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia and infection</b> <b>4444X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>10 years</b> <b>Indef.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U. S. Naval Hospital, NNMC</b>			
20f. (City or town) <b>Bethesda</b>		(County) <b>Maryland</b>		(State) <b>Maryland</b>			
21. I certify that I attended the deceased from <b>April 27</b> , 19 <b>59</b> , to <b>May 6</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 6</b> , 19 <b>59</b> , and that death occurred at <b>8:15 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b> DATE SIGNED <b>4-7-59</b>							
ACTUAL SIGNATURE <b>[Signature]</b> PHYSICIAN'S NAME (Type) <b>O. M. YOUNG, LT, MC, USN</b> Bethesda 14, Maryland							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-12-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			
22d. LOCATION (City, town, or county) <b>Arlington</b>		(State) <b>Virginia</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers, 517 11th St., S.E., Washington, DC</b>			
24a. REC'D BY REGISTRAR <b>MAY 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be described for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5778 CERTIFICATE OF DEATH

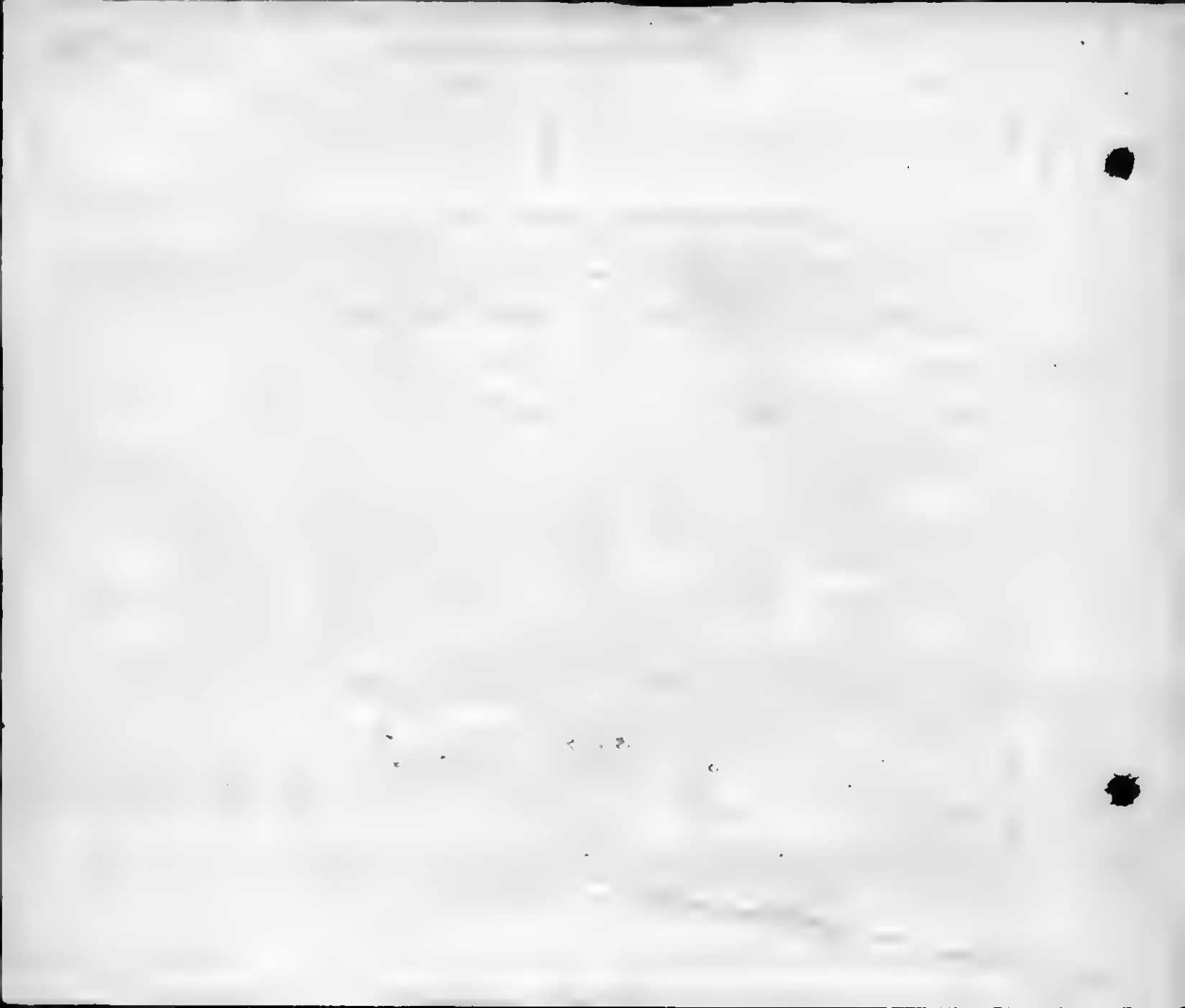
Reg. Dist. No. 05759

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
c. LENGTH OF STAY IN <u>28 1/2 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>6102 SWANSEA ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>ERIC</u> Middle <u>HELLEKJAER</u> Last <u>HELLEKJAER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>15</u> Year <u>19 59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 14, 1959</u>
9. AGE (In years last birthday) <u>yr.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>PER HELLEKJAER</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANE SELLECK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Per Hellekjaer - 6102 - Swansea St.</u>	
17. INFORMANT <u>Per Hellekjaer - 6102 - Swansea St.</u>		Address <u>Be Hordstap</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asystole</u> DUE TO <u>Secondary prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Secondary prematurity</u> DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>5/14</u> , 19 <u>59</u> , to <u>5/15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/15</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Robert E. Stadelman</u> M.D.		ADDRESS (Street, city or town, state) <u>1717 N. St. N.W.</u> DATE SIGNED <u>5/16/59</u>
PHYSICIAN'S NAME (Type) <u>Robert E. Stadelman, M. D.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>5/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>
22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 19 59</u>
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8199

CERTIFICATE OF DEATH

05760  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> c. LENGTH OF STAY IN 1b <b>Rockville</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>908 Viers Mill Rd.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>1724 Grandin Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>MAY</b> Last <b>HENLEY</b>		4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 22, 1888</b>
9. AGE (In years last birthday) <b>70</b> yrs		10. IF UNDER 1 YEAR <b>5</b> Months <b>1</b> Days	11. IF UNDER 24 HRS <b>Hours</b> <b>Min</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Edward Henley</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Butt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Yes</b> <b>Arthur R. Henley</b> Address <b>Damascus, Maryland</b>	
17. MEDICAL CERTIFICATION 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Wm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO <b>ASCVD</b> (c) <b>Indist.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C. A. 7.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/1</b> , 19 <b>52</b> , to <b>5/23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5/23</b> , 19 <b>57</b> , and that death occurred at <b>1:05 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>809 Viers Mill Rd. Rockville, Maryland</b> DATE SIGNED <b>5/24/57</b>			
ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-25-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Montgomery County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b> ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 27 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur R. Henley</b>	





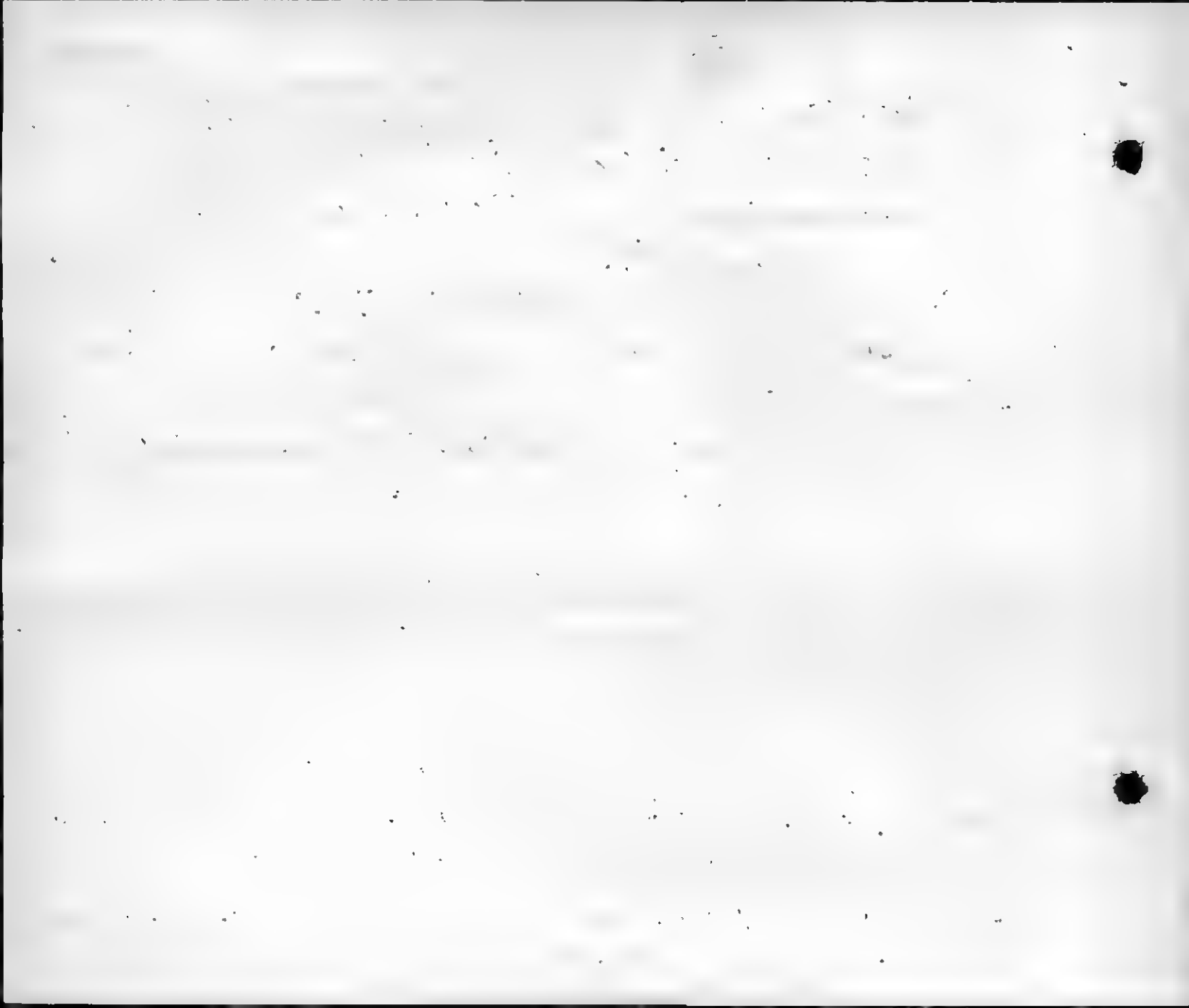
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5779

CERTIFICATE OF DEATH

Reg. Dist. No. 05761

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Molly</u> Middle <u>M.</u> Last <u>HEARY</u>		4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>7c</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2 1872</u>
9. AGE (In years last birthday) <u>87</u>		10. IF UNDER 1 YEAR <u>2</u> Months <u>4</u> Days <u>6</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stemmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Clark</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Kearmf</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Elsie Hickman</u> Address <u>Daughter - Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> DUE TO (b) <u>Bronchitis</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic Bronchitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15</u> <u>days</u> <u>Indef.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 1, 1958</u> to <u>May 8, 1959</u> that I last saw the deceased alive on <u>5/8/59</u> and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>5/8/59</u>	
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>		<u>Rockville, Md.</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial-Transit</u>	22b. DATE THEREOF <u>5/12/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Berkley Co. W. Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 12 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5780

## CERTIFICATE OF DEATH

05762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Washington D.C.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Washington D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5220 Marilyn Drive, Glenman Pk.</u>		e. STREET ADDRESS <u>5220 Marilyn Dr. Glenman Pk.</u>	
3. NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u>Daniel</u> Last <u>Higgins</u>		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 24, 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer (Farm)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Simpson, Minn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Higgins</u>		14. MOTHER'S MAIDEN NAME <u>Donative</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Son</u>		Address <u>5220 Glenman Pk.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gastroc dilatation</u> 14.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral thrombosis</u> DUE TO (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1959</u> to <u>May 14, 1959</u> , that I last saw the deceased alive on <u>April 30, 1959</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D.		ADDRESS (Street, city or town, state) <u>4890 Battery Lane Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut</u>		DATE SIGNED <u>5/14/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-16-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		ADDRESS <u>Wash. D. C.</u>	
24a. REC'D BY REGISTRAR <u>Francis J. Collins</u>		24b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>	
DATE <u>MAY 18 '59</u>			



5781

## CERTIFICATE OF DEATH

Reg. Dist. No.

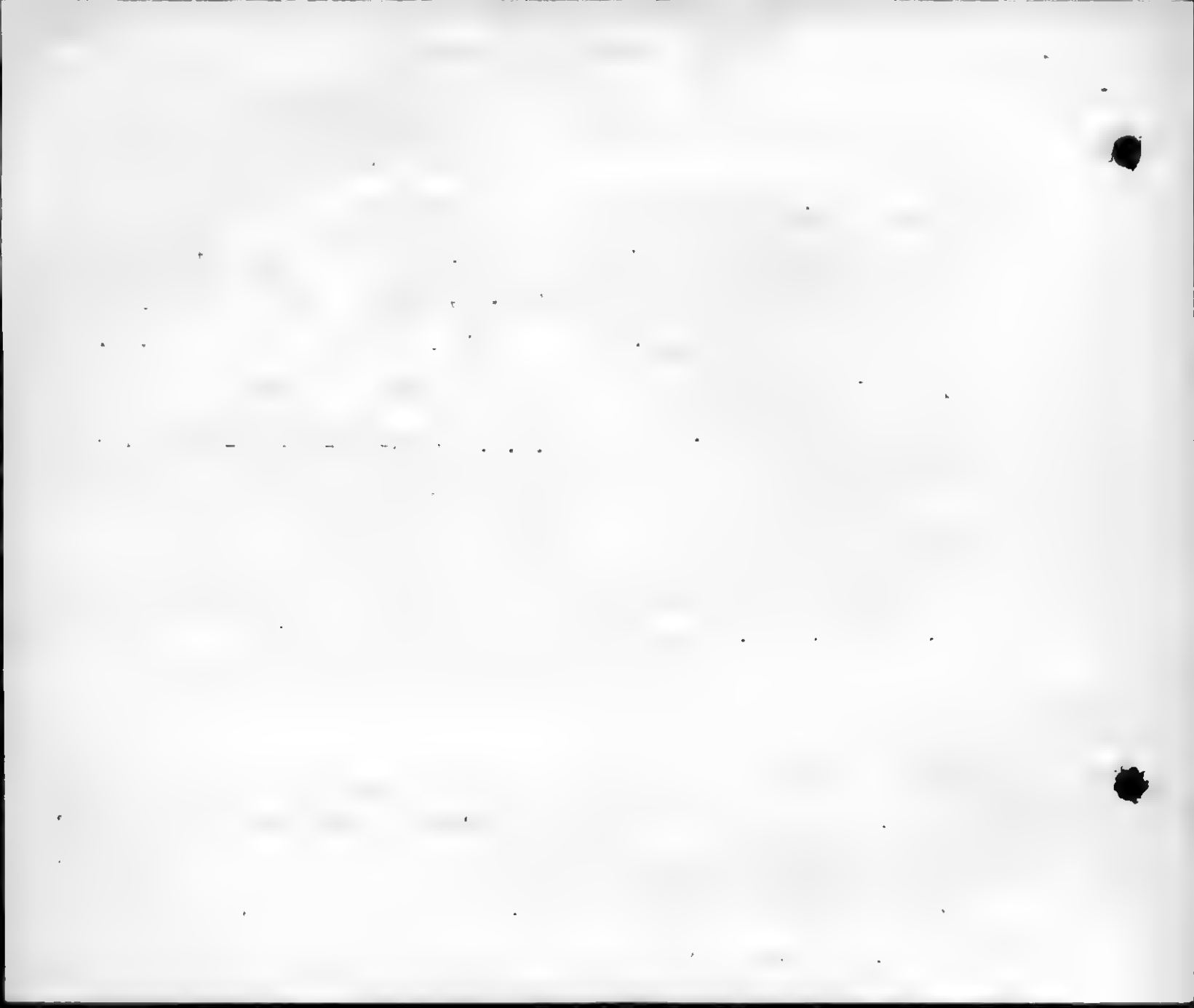
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Rest Home</b>		e. STREET ADDRESS <b>9616 Old Spring Road</b>	
3. NAME OF DECEASED (Type or print) First <b>LILLIAN</b> Middle <b>HUBBARD</b> Last <b>HOLCH</b>		4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1875</b>
9. AGE (In years last birthday) <b>83</b> yrs		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>26</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Geneologist</b>	
11. BIRTHPLACE (State or foreign country) <b>Rhode Island</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Hiram Wilbur Hubbard</b>		14. MOTHER'S MAIDEN NAME <b>Josephene Ferguson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>W.R.F. Adams-sin-in-law-same as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arterio-sclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>* patient under medical supervision other than my own, at nursing home for 1 yr.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1</b> 19 <b>59</b> to <b>May 1</b> 19 <b>59</b> , that I last saw the deceased alive on <b>May 1</b> 19 <b>59</b> , and that death occurred at <b>5:30</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10620 Georgia Ave. Silver Spring</b> DATE SIGNED <b>5/1/59</b>			
ACTUAL SIGNATURE <b>Donald Nelson</b> M.D.		10620 Georgia Ave. Silver Spring	
PHYSICIAN'S NAME (Type) <b>Donald Nelson</b>		<b>Maryland</b> <b>5/1/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>5/4/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>MAY 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the health certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9-58



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05764
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>5782</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>18 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10512 Lorraine Ave</u>					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10512 Lorraine Ave</u> d. STREET ADDRESS <u>10512 Lorraine Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Thaddeus Leroy Hopkins</u> First Middle Last 4. DATE OF DEATH <u>May 20 1959</u> Month Day Year					5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-5-1901</u> 9. AGE in years (last birthday) <u>58</u> yrs WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>More Projection</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>					11. BIRTHPLACE (State or foreign country) <u>U.S.C.</u>
13. FATHER'S NAME <u>Wm F. Hopkins</u>					14. MOTHER'S MAIDEN NAME <u>Mamie Hankford</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <u>Wm F. Hopkins</u> Address <u>101 S. Hampton Dr Silver Spring Md</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Barbiturate poisoning</u> <u>871.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>871.9</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Has been taking considerable medication for arthritis</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)					20g. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>										
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>5-20-59</u>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>5-23-59</u>					22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cmtry</u>
22d. LOCATION (City, town, or county) (State) <u>Prince George's Maryland</u>					24a. REC'D BY REGISTRAR <u>Arthur S. Hanna</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>DEAL FUN. Home 4812 Ga Ave NW</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>					





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5726

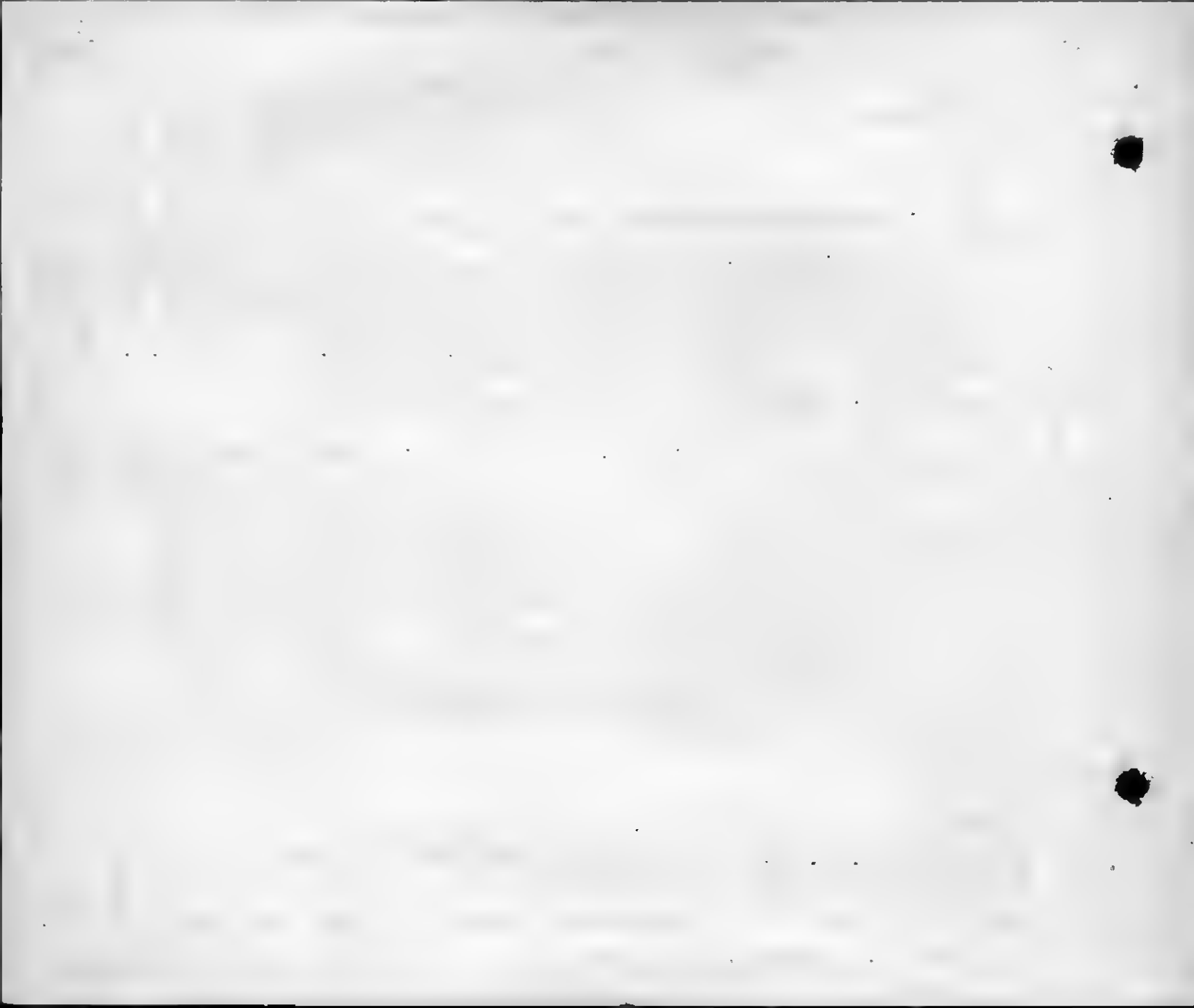
CERTIFICATE OF DEATH

Reg. Dist. No.

05765

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>Rockville</b>		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. STREET ADDRESS <b>802 Roxboro Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLIFORD L. HOWARD</b>		First		Middle		Last		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 59</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-15-24</b>		9. AGE (in years last birthday) <b>35</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>7</b>		IF UNDER 24 HRS Hours <b>15</b> Min. <b>15</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>Cliford L. Howard</b>		14. MOTHER'S MAIDEN NAME <b>Lucie Gallaher</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>Catherine G. Howard - Item #2- Wife</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 MIN</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>1958-49</b> to <b>5-22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/22</b> , 19 <b>59</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>615 W. Montgomery Ave. Rockville, Md.</b>		DATE SIGNED <b>5-22-59</b>		ACTUAL SIGNATURE <b>W. G. Hall</b>	
PHYSICIAN'S NAME (Type) <b>W. G. Hall, 615 W. Montgomery Ave., Rockville, Maryland</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-25-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Darnestown Presby. Ch. Cem - Montgomery Co., Md.</b>		22d. LOCATION (City, town, or county) (State)		24a. REC'D BY REGISTRAR <b>DATE MAY 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DATE		MAY 27 '59		Arthur S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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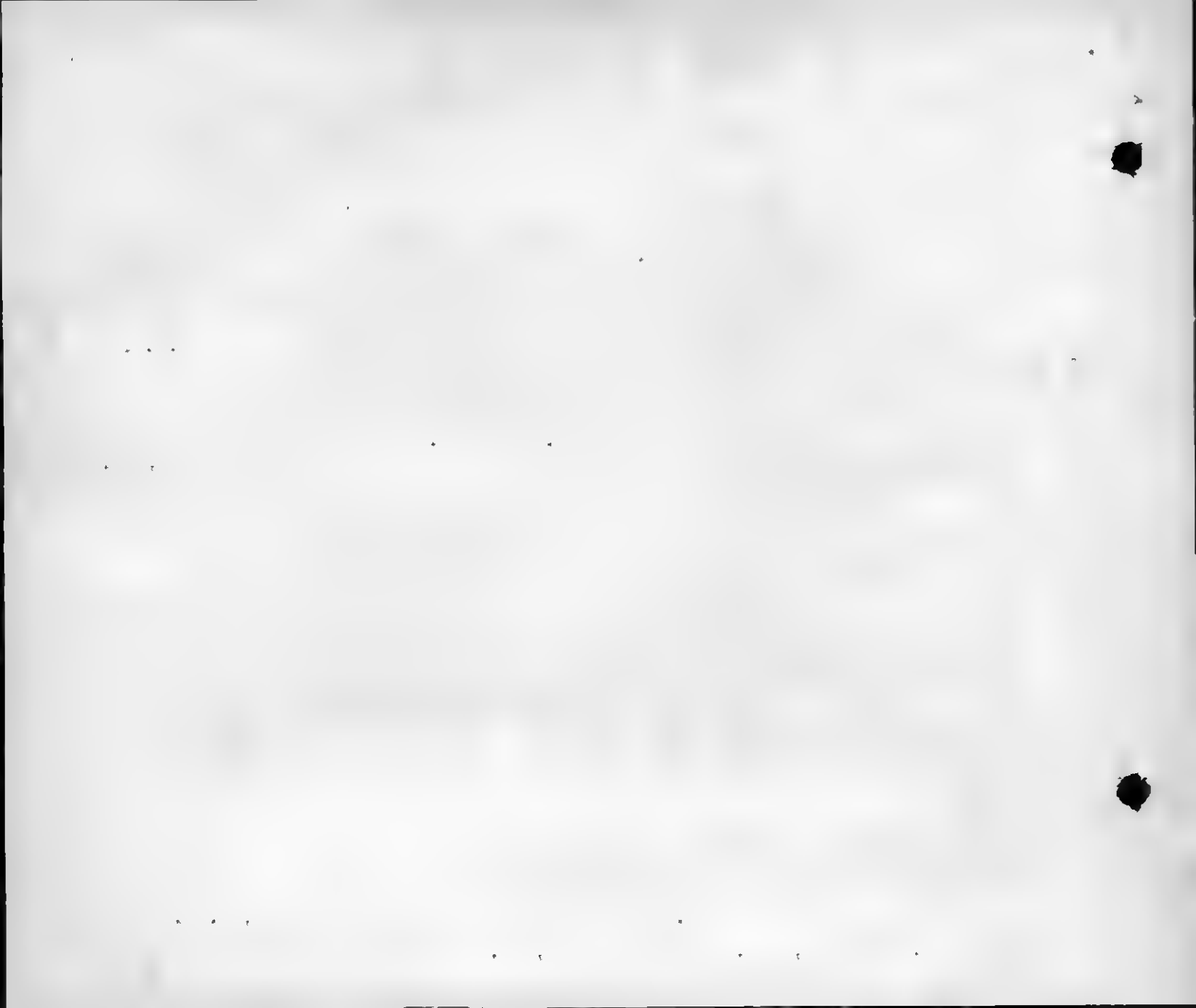
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5783 CERTIFICATE OF DEATH

05766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>56</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>424 SOUTHWEST DRIVE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>424 SOUTHWEST DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ESTHER</b> Middle <b>O.</b> Last <b>IANNIELLO</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/17/78</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS: Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>VINCENT OLIVIERI</b>		14. MOTHER'S MAIDEN NAME <b>JUSTINE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>Mrs. Harold E. Cropper, 424 Southwest Drive Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>- acute coronary occlusion</b> DUE TO <b>- arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-</b> DUE TO (c) <b>-</b> INTERVAL BETWEEN ONSET AND DEATH <b>1.5 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-1-59</b> , 19 <b>59</b> , to <b>5-21-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5-21-59</b> , 19 <b>59</b> , and that death occurred at <b>9:42 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>5-22-1959</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Veronica Trout</b> M.D. <b>5-22-1959</b>			
PHYSICIAN'S NAME (Type) <b>VERONICA TROUT</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>ENTOMBMENT</b>		22b. DATE THEREOF <b>5/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR <b>MAY 26 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5784

## CERTIFICATE OF DEATH

Reg. Dist. No.

05767

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b> c. LENGTH OF STAY IN 1b <b>11 months</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>REST HAVEN CONVALESCENT HOME</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON GROVE</b> d. STREET ADDRESS <b>410 BROWN STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>M</b> Last <b>Isherwood</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/11/84</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSPECTOR (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Highway Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT ISHERWOOD</b>		14. MOTHER'S MAIDEN NAME <b>ISABELLA DARBY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Ruth K. Isherwood, 410 Brown St.</b>		Address <b>Washington Grove, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO <b>Cardiac Asthma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis, Hypertension</b> (c) <b>Cerebral Arteriosclerosis, Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> , 19 <b>57</b> , to <b>May 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 30</b> , 19 <b>59</b> , and that death occurred at <b>6 A. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>108 N. Frederick Ave.</b> DATE SIGNED <b>Luciano L. Leal</b>			
ACTUAL SIGNATURE <b>Luciano L. Leal</b> M.D.		PHYSICIAN'S NAME (Type) <b>Luciano L. Leal Gaithersburg Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/6/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC. Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR <b>MAY 5 59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.



## 5715 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>8402 Barron St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sherman Wesley Jack</u>		4. DATE OF DEATH Month Day Year <u>5-2-1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-4-94</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>William H. Jack</u>		14. MOTHER'S MAIDEN NAME <u>Mervie Mosher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive failure</u> DUE TO (b) <u>Ventricular flutter</u> DUE TO (c) <u>Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u> <u>17 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 14, 1959</u> to <u>May 2, 1959</u> that I last saw the deceased alive on <u>May 1, 1959</u> and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eino Magi</u> M.D.		ADDRESS (Street, city or town, state) <u>918 University Bldg. E</u> DATE SIGNED <u>5/2/59</u>	
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		<u>Silver Spring, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 4, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Leopold Washington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Hume</u>		ADDRESS <u>254 Carroll St. N.W. D.C.</u>	
24c. REC'D BY REGISTRAR <u>May 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# Item 9 Film 6243 6-2-59 et 5785 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

## CERTIFICATE OF DEATH

05769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN TB <b>2 HR. 10 MIN.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC.</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DERWOOD</b> d. STREET ADDRESS <b>MELINDA RUSSELL NURSING HOME</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>IDA J. JACKSON</b>		4. DATE OF DEATH Month Day Year <b>MAY 16 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/17/1880</b>
9. AGE (In years last birthday) <b>79 78 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN BOSWELL</b>		14. MOTHER'S MAIDEN NAME <b>ANNA PROCTOR</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerotic Heart disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/11</b> , 19 <b>59</b> , to <b>5/16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/16</b> , 19 <b>59</b> , and that death occurred at <b>1:10 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Sandy Spring, Maryland</b> <b>5/17/59</b> ACTUAL SIGNATURE <b>J. W. Bird</b> M.D. PHYSICIAN'S NAME (Type) <b>J. W. BIRD, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Calvary</b>		22d. LOCATION (City, town, or county) (State) <b>Spencerville Ind.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert C. Shanden</b>		ADDRESS <b>Rockville Ind.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

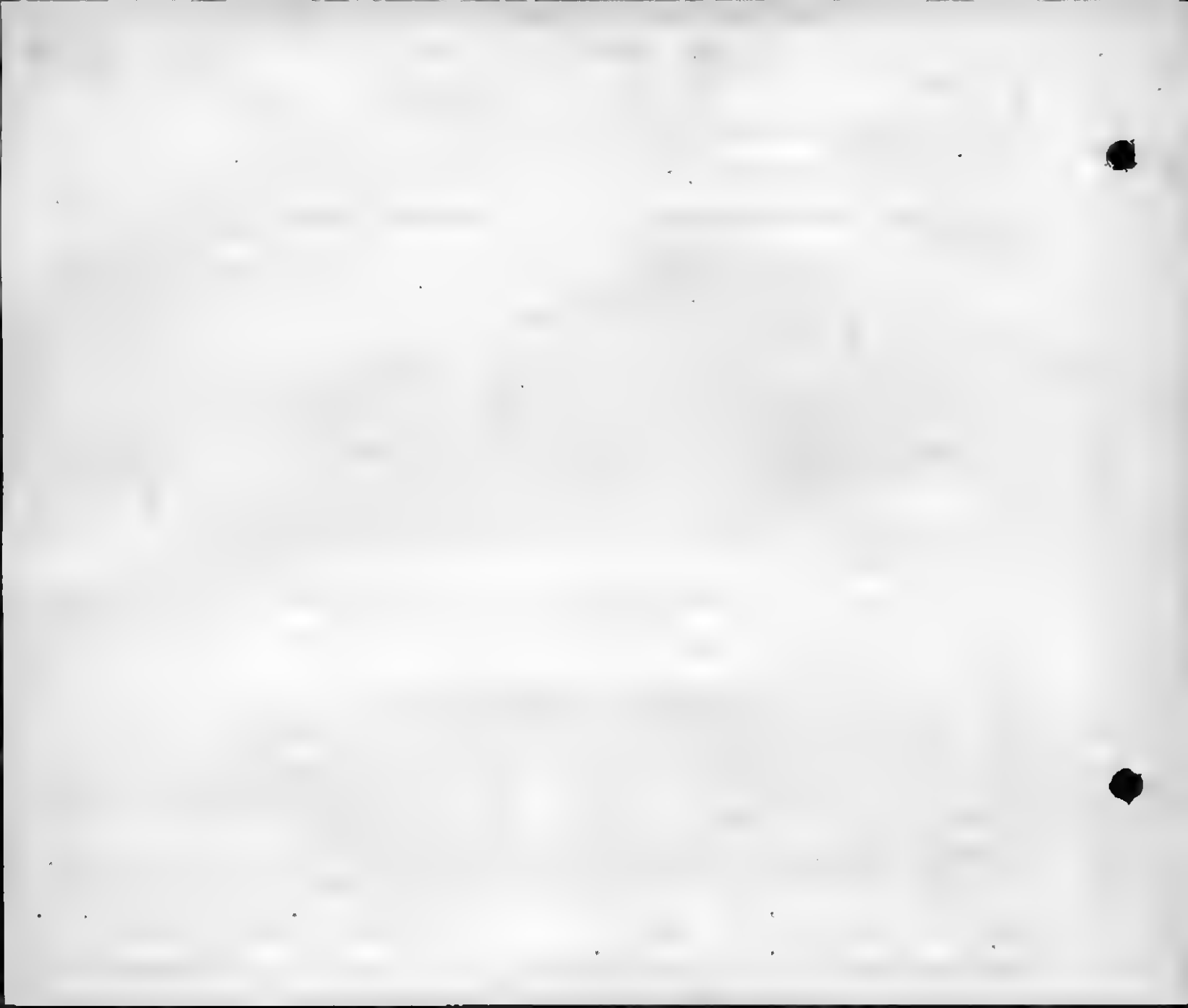


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5786 CERTIFICATE OF DEATH

Reg. Dist. No. 05770

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>GORDON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>2 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>128 AMES ROAD</u>				d. STREET ADDRESS <u>NONE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUTISHA ELIZABETH JACKSON</u>				4. DATE OF DEATH Month Day Year <u>MAY 27 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 25, 1874</u>	
9. AGE (In years last birthday) <u>84 yrs</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William R. Lancaster</u>			
14. MOTHER'S MAIDEN NAME <u>Betsy Ann Mahalia Pirkle</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>MARTHA HILLS</u> Address <u>128 AMES RD, Silver Spring, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coreinoma of the Pituitary Gland</u> DUE TO (c) <u>6 1/2 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>DEC 27, 1957</u> to <u>MAY 27, 1959</u> , that I last saw the deceased alive on <u>MAY 25, 1959</u> , and that death occurred at <u>3:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James L. Laubach</u> M.D.				ADDRESS (Street, city or town, state) <u>1806 FOX ST Hyattsville, MD</u>			
PHYSICIAN'S NAME (Type) <u>James L. Laubach</u>				DATE SIGNED <u>May 27th, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 28th, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oothoaloga Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Gordon Co. near Adairsville, Ga.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Company, Riverdale, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5787 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05771

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>18 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		d. STREET ADDRESS <u>3908 Mertford St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3908 Mertford St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Milton Jackson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>19 59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-24-1904</u>	9. AGE (in years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>23</u>	IF UNDER 24 HRS Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aqueduct Center</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>Benny Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Amie Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Rosie Jackson (wife)</u>		Address <u>Stine 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>454.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5-23-59</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Swodlow</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate within 24 hours of death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



5788

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooks Grove Foundation</u>				e. STREET ADDRESS <u>7311 Flower Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>MAUDE AGNES JENKINS</u>				4. DATE OF DEATH <u>May 11, 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 26, 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
Months		Days		Hours		Min.	
11. BIRTHPLACE (State or foreign country) <u>Dickinson Center N.Y.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Wallace Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>Elmira Clarke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema - acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute-Far advanced Rheumatoid arthritis + Total Deformity</u> DUE TO (c) <u>20 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 1957, to <u>May</u> , 1959, that I last saw the deceased alive on <u>10 May</u> , 1959, and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Bosley Ziegler M.D.</u>				ADDRESS (Street, city or town, state) <u>Alney Md</u>			
PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>				DATE SIGNED <u>11 May 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 13, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Eastwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>South Lancaster, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>234 Calver St. Washington D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
24a. REC'D BY REGISTRAR <u>MAY 13 59</u>				DATE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05773

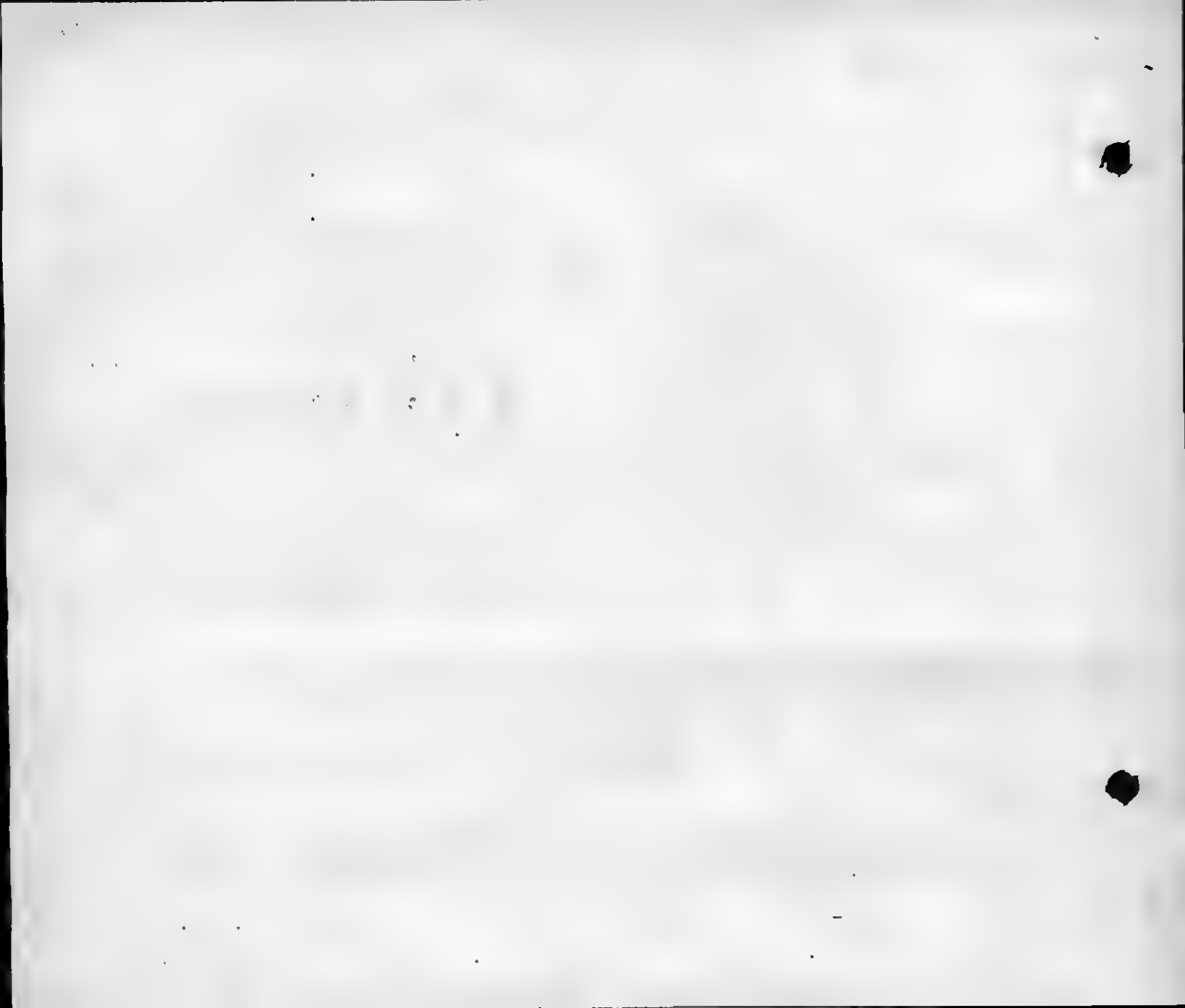
5789

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut an Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>24 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. STREET ADDRESS <u>5077 Bradley Blvd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Diane YVONNE Jernigan</u>		4. DATE OF DEATH Month Day Year <u>May 10 19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30, 1953</u>
9. AGE (In years last birthday) <u>5</u> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Senadi, Japan</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Louis E. Jernigan</u>		14. MOTHER'S MAIDEN NAME <u>Betty Lois Woodward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Louis E. Jernigan</u> Address <u>Item #2</u>		18. AS ABOVE <u>As above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Encephalomalacia</u> DUE TO (c) <u>Cardiac Arrest (During appendectomy)</u>		INTERVAL BETWEEN ONSET AND D.E.A. <u>21 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pending</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Naturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Merrill M. Cross</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <u>MERRILL M. CROSS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMAT ON, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-12-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



5790

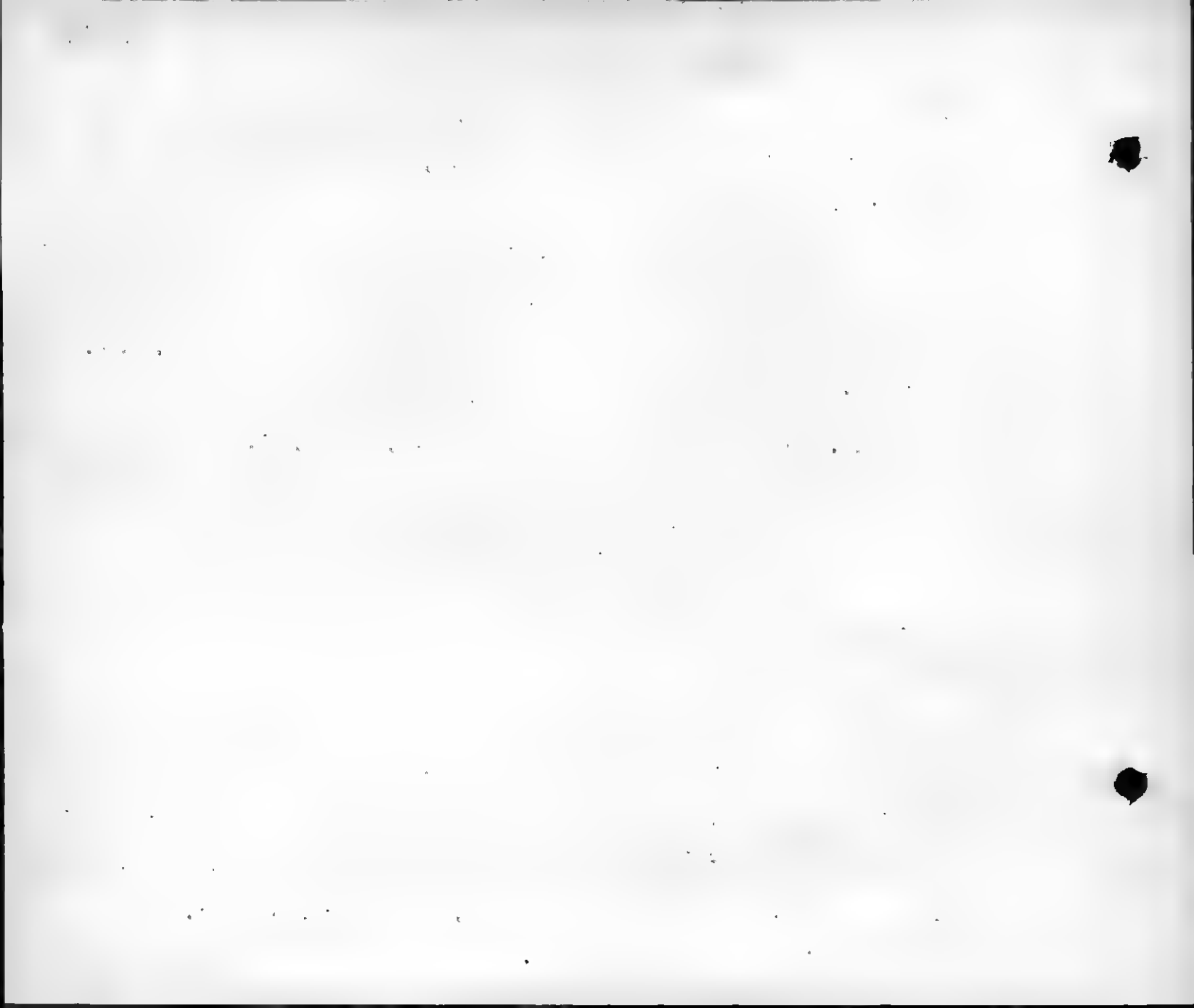
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg (Rural)</b> c. LENGTH OF STAY IN 1b <b>2 Months</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ammons Nursing Home</b>		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ashton</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Joseph W Johnson</b>		4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>19 59</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Dec. 20, 1879</b>
9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph H. Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Emma Ann Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>W.W. # 1</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Sarah Johnson, Ashton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Nephritis</b> DUE TO <b>Infection of Chronic Nephritic Kidney</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>One kidney removed.</b> DUE TO <b>Nephritic Hypertension</b> (c) <b>Hemiplegia</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemiplegia</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 21, 1936</b> , to <b>May 18, 1959</b> , that I last saw the deceased alive on <b>May 18, 1959</b> , and that death occurred at <b>1:00 P.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5200 59</b> DATE SIGNED <b>5-20-59</b> ACTUAL SIGNATURE <b>Webster Sewell</b> M.D. PHYSICIAN'S NAME (Type) <b>Webster Sewell, M.D.</b> Rt. 1 Silver Sp. Inds.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/22/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Surden</b> ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper(s). Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5791

## CERTIFICATE OF DEATH

Reg. Dist. No.

05775

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8009 Eastern Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary A.</b> Middle <b>Johnson</b> Last		4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/20/71</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Sheppard</b>		14. MOTHER'S MAIDEN NAME <b>Alice Hampton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Edith J. Brown same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA, LEFT LUNG</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>CEREBRAL THROMBOSIS RT</b> (c) <b>HYPERTENSIVE HEART DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>1 1/2 years</b> <b>YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROSIS GEN - CHRONIC PYELONEPHRITIS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1948</b> 19 <b>May 3</b> 19 <b>59</b> , that I last saw the deceased alive on <b>May 3</b> 19 <b>59</b> , and that death occurred at <b>2:30 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Jacob Ceppos, M.D.</b>		M.D. <b>4-316-1472 S. WASHINGTON, D.C.</b>	
PHYSICIAN'S NAME (Type) <b>JACOB CEPPOS, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5/6/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 5 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5792 CERTIFICATE OF DEATH

Reg. Dist. No. 05776

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3117 Plyers Mill Rd.</b>		e. STREET ADDRESS <b>3117 Plyers Mill Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>AGNES</b> Last <b>JOYCE</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>9</b> Year <b>19-59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 19, 1889</b>
10a. USUAL OCCUPATION (Give kind of work done during part of working life even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (In years last birthday) <b>69</b>
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Richard O'Connor</b>		14. MOTHER'S MAIDEN NAME <b>Johanna Reidern</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Thomas F. Joyce</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY ARTERIO SCLEROSIS</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS.</b> <b>56 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1955</b> , 19____, to <b>May 9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 9</b> , 19 <b>59</b> , and that death occurred at <b>6:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10609 CONCORD ST. MAY 9-59</b> DATE SIGNED ACTUAL SIGNATURE <b>Robert T. Thibodeau</b> M.D. PHYSICIAN'S NAME (Type) <b>ROBERT T. THIBODEAU KENSINGTON, MD</b>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/13/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Josephs Cem</b>	22d. LOCATION (City, town, or county) (State) <b>East McKeesport, Penna</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>MAY 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	





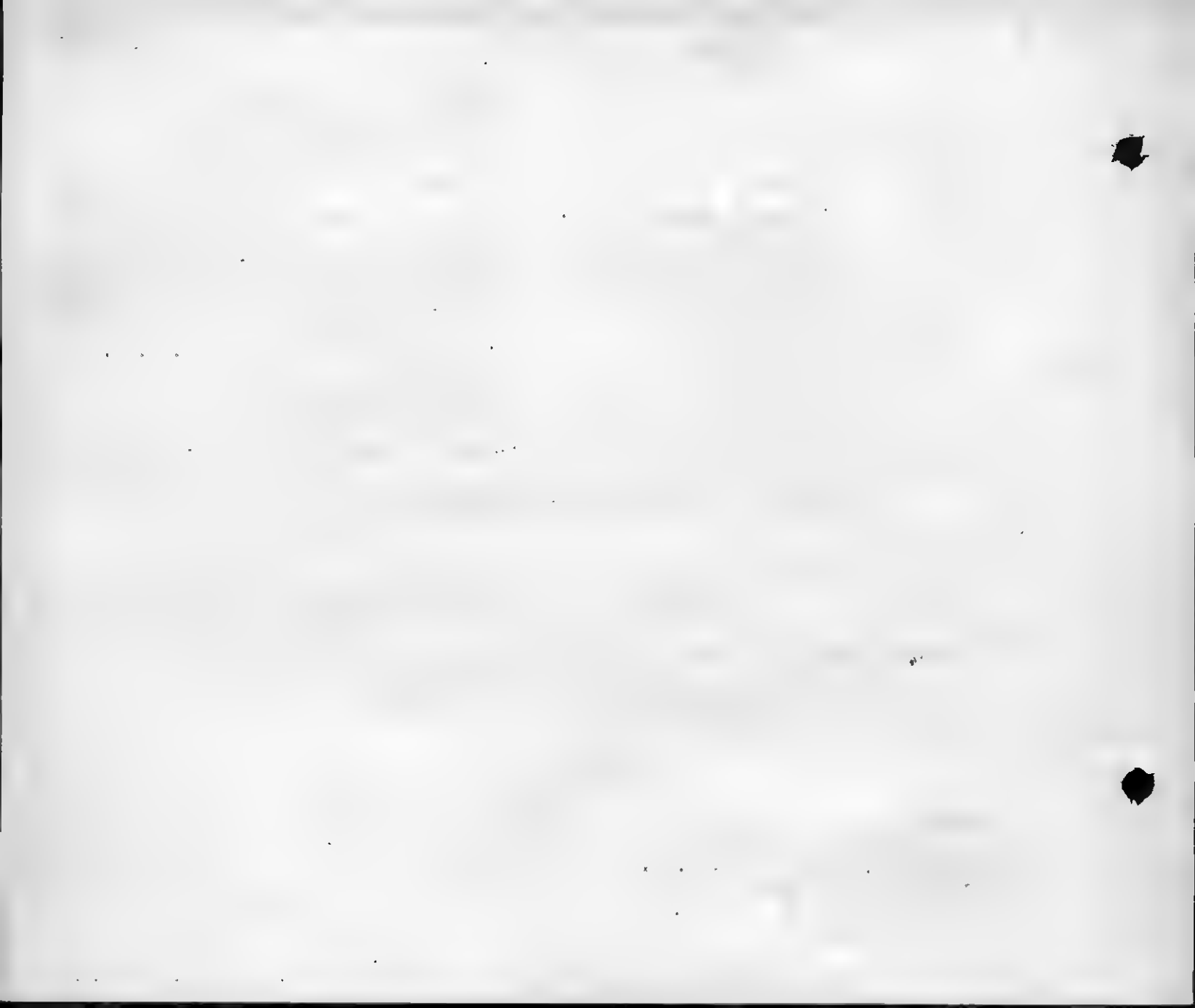
## 5793 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>199 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Passaic</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>201 Dayton Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>(none)</b> Last <b>Kampelman</b>				4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 5, 1888</b>	
9. AGE (In years last birthday) <b>70 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Milliner</b>		11. BIRTHPLACE (State or foreign country) <b>Romania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Alter Gottlieb</b>				14. MOTHER'S MAIDEN NAME <b>Susan Fitzer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unavailable</b>		17. INFORMANT <b>The Medical Record Address</b> <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adeno carcinoma of the lung</b> <b>16.3X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 10, 1958</b> , to <b>May 28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 28</b> , 19 <b>59</b> , and that death occurred at <b>11:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5/29/59</b> ACTUAL SIGNATURE <b>G. Richard Lee</b> M.D. <b>The National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>G. Richard Lee, M. D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, or other disposition (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>5-31-59</b>		<b>Mt. Carmel Cemetery</b>		<b>Cypress Hills, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danzansky &amp; Sons</b> ADDRESS <b>3501 14th Street, N.W.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5794 CERTIFICATE OF DEATH

Reg. Dist. No.

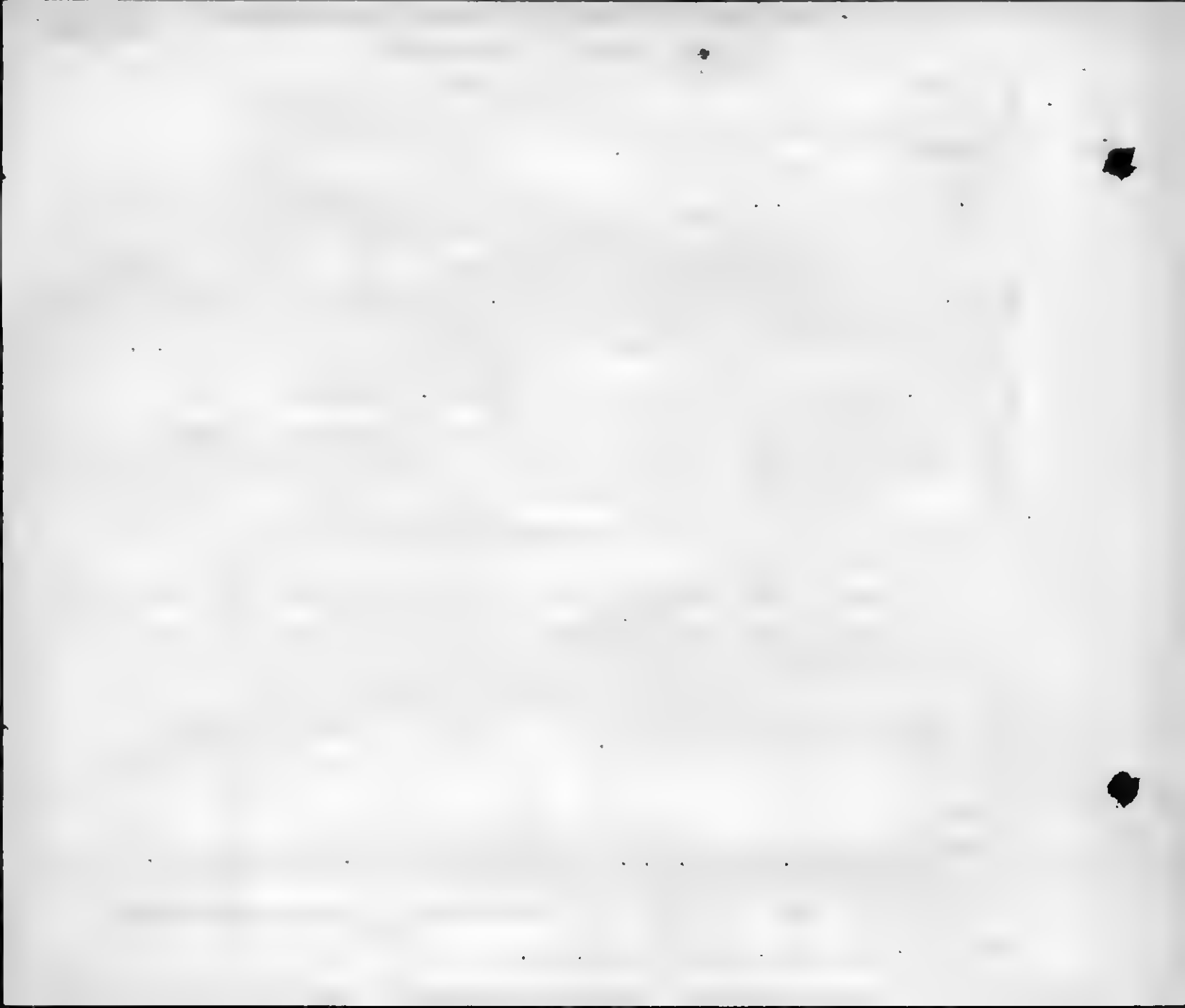
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>5324 Pooks Hill Ct.</b>		d. STREET ADDRESS <b>5324 Pooks Hill Ct.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Susan Moss Kellam</b>		4. DATE OF DEATH Month Day Year <b>May 29, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 22, 1875</b>
9. AGE (In years last birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>8 7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Bahamas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Silas W. Moss</b>		14. MOTHER'S MAIDEN NAME <b>Julia G. Griffin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Dorothy Kellam-Item #2- daughter</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Urinary Sepsis</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adenocarcinoma of Urinary bladder</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 15</b> , 19 <b>58</b> , to <b>May 29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 21</b> , 19 <b>59</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert G. Angle</b>		ADDRESS (Street, city or town, state) <b>5009 Del Ray Ave., Bethesda, Md.</b>	
DATE SIGNED <b>5/29/59</b>			
PHYSICIAN'S NAME (Type) <b>Robert G. Angle, M.D.</b>		<b>5009 Del Ray Ave., Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>6-1-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 2 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

Coroner M Montgomery County notified this date and approved sig nature.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



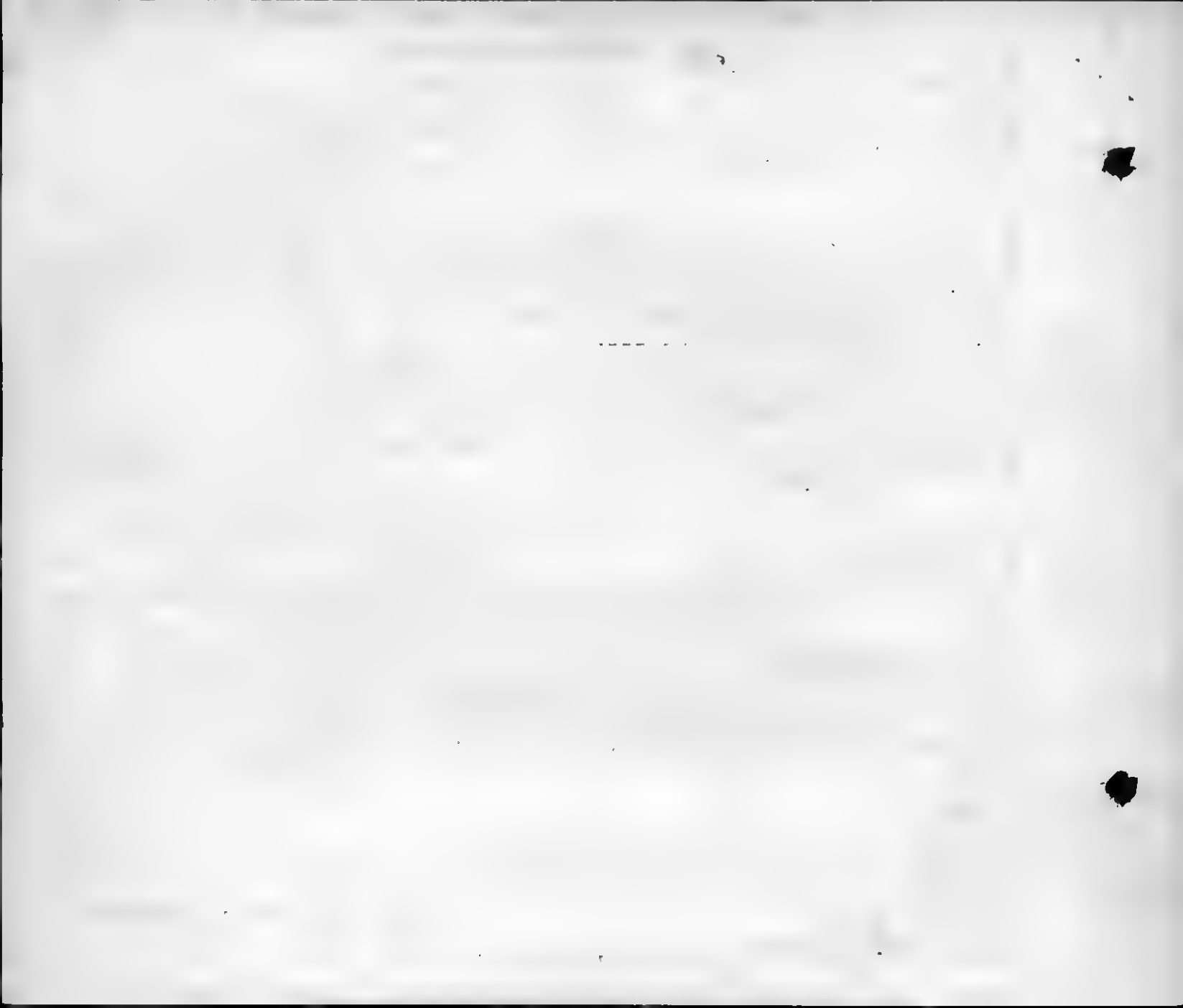
5795 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4405 Sawl Rd</u>		e. STREET ADDRESS <u>14405 Sawl Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>FRED CHARTERS Kelly</u>		4. DATE OF DEATH <u>May 23</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/27/82</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTHOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert A. Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Alice Charters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>44-10-310</u>	
17. INFORMANT <u>Mrs Kelly</u>		Address <u>4405 Sawl Rd Kensington Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 1520 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition + cachexia</u> DUE TO (c) <u>Carcinoma of Rt Colon</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>3 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>May 19</u> 19 <u>59</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>May 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>59</u> , and that death occurred at <u>3:10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>8218 Wisc Ave. Beth Md</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT G. BREWER M.D.</u>		DATE SIGNED <u>5/23/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>5/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>MAY 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Form 6243 6-3-59 et

5796

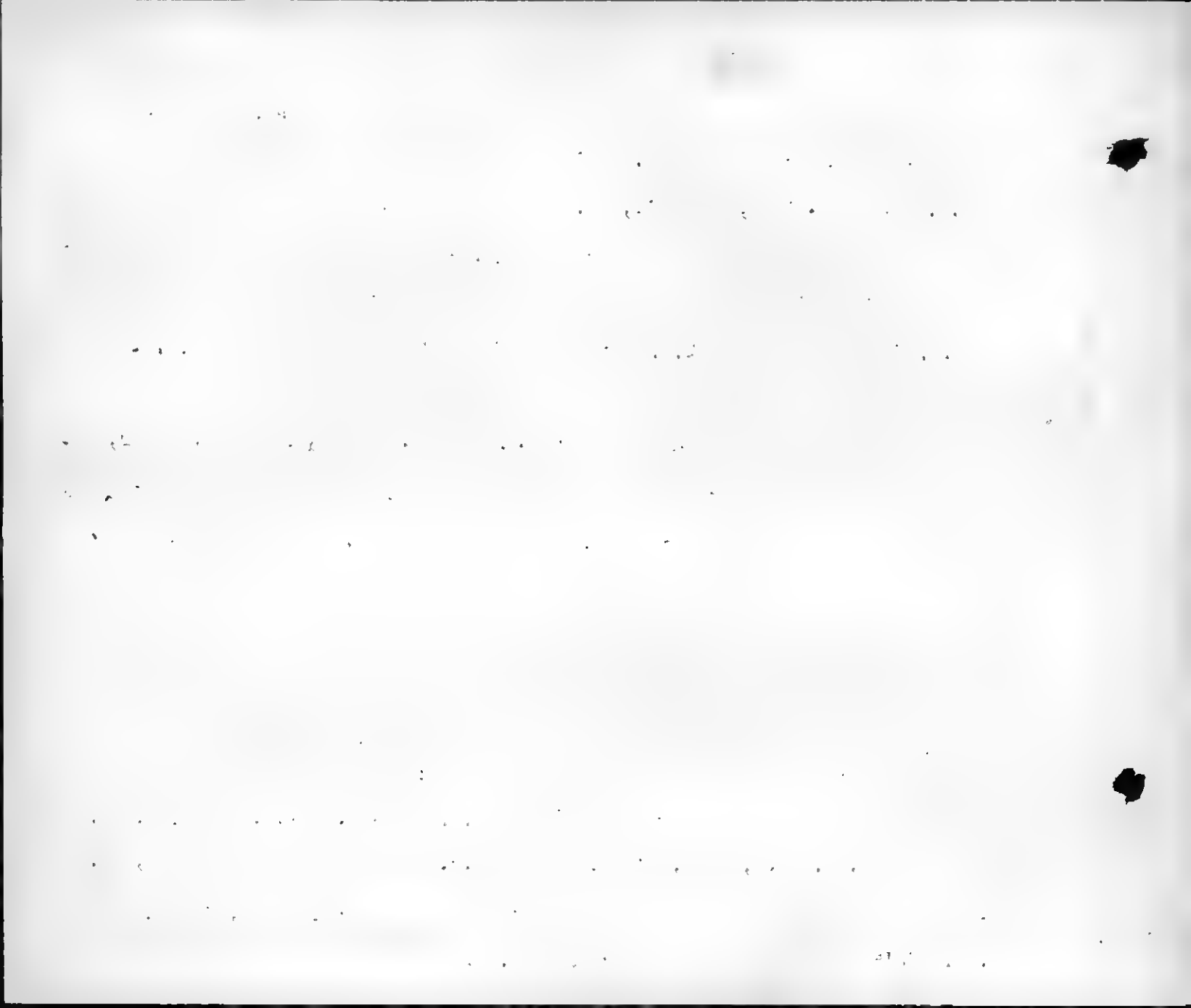
## CERTIFICATE OF DEATH

Reg. Dist. No.

05780

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">b. COUNTY <b>Prince Georges</b></span> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Bethesda (Rural)</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glassmanor</b> c. STREET ADDRESS <b>406 Maury Avenue</b> d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Roy Cecil Kesler</b>		<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>26</b> Year <b>1959</b>		<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>Caucasian</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>18 February 1921</b> <b>9. AGE</b> (In years last birthday) <b>38 3/4</b> yrs <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Navy</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>North Carolina</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Henry Kesler</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Carrie Goodman</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WWII</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>INFORMANT</b> <b>Mrs. Bertha F. Kesler (Wife) Glassmanon, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>subarachnoid hemorrhage</b> DUE TO <b>bleeding posterior communicating aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3 weeks</b> DUE TO (c) <b>3 weeks</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 weeks</b>		
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o m p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that I attended the deceased from 2-28-1959, to 5-26-1959, that I last saw the deceased alive on 26 May 1959, and that death occurred at 4:30 PM, from the causes and on the date stated above</b> <b>ADDRESS (Street, city or town, state) DATE SIGNED</b> <b>ACTUAL SIGNATURE</b> <i>Matthew W. Wood MD</i> <b>M.D. U.S. Naval Hospital, Bethesda, Md.</b> <b>PHYSICIAN'S NAME (Type)</b> <b>M. W. WOOD, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md.</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>5-29-59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>			
<b>22d. LOCATION (City, town, or county) (State)</b> <b>Arlington, Virginia</b>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. W. LEE'S SONS 300 4th Street, N.E., WASH., D.C.</b> <b>24a. REG'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Hume</i> <b>DATE</b> <b>MAY 28 59</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.





5797

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institutions: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>40 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>4500 South 34th St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John F. KIERNAN</u>				4. DATE OF DEATH Month Day Year <u>may 11 19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/11/20</u>	9. AGE (In years last birthday) <u>39</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>International Bank</u>		11. BIRTHPLACE (State or foreign country) <u>New York-Bx.</u>	
13. FATHER'S NAME <u>Joseph Francis Kiernan</u>				14. MOTHER'S MAIDEN NAME <u>Madeline Mc Guinness</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>66B-14-6903</u>		17. INFORMANT <u>Virginia Kiernan (wife)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain failure, acute</u>						<u>36 hours</u>	
DUE TO <u>5X1.0</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CIRRHOSIS, LIVER</u>						<u>1 year</u>	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>FEB 10</u> , 19 <u>59</u> , to <u>MAY 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAY 8</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <u>Philip R. James</u>				M.D.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 15/1959</u>		<u>Arlington National Cemetery</u>		<u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. Murphy</u>				ADDRESS <u>Arlington, Va</u>		24a. REC'D BY REGISTRAR	
						24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	
				DATE <u>MAY 13 1959</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5798 CERTIFICATE OF DEATH

Reg. Dist. No.

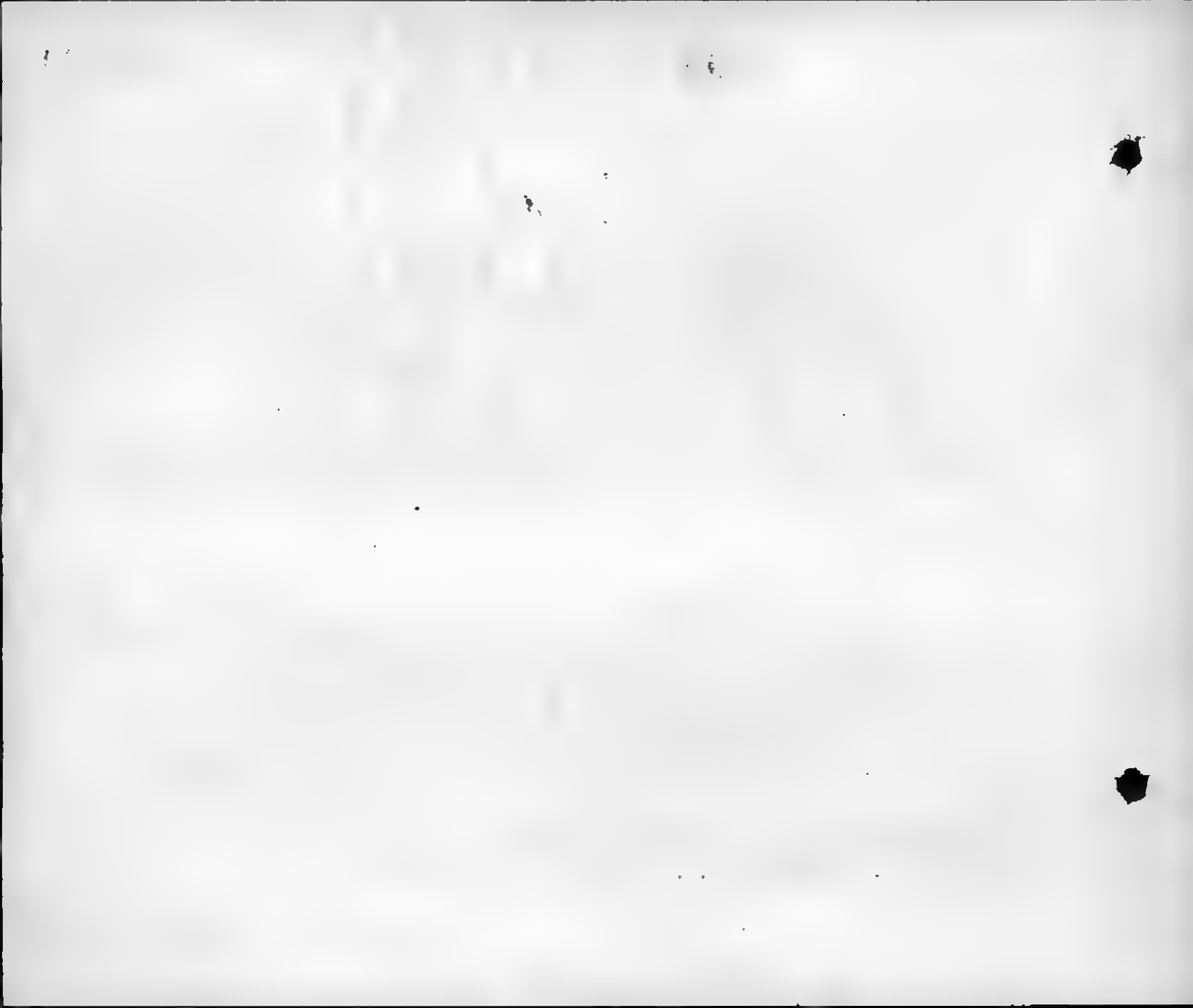
05782

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>36 hrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksburg</b> d. STREET ADDRESS <b>Hospital Record, Olney, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>William - Kost</b>				4. DATE OF DEATH Month Day Year <b>May 15 19 59</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-17-1884</b>	
9. AGE (In years last birthday) <b>74</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Librarian</b>		11. BIRTHPLACE (State or foreign country) <b>Switzerland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Kost</b>				14. MOTHER'S MAIDEN NAME <b>Therese Kost</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>577-09-4008</b>		17. INFORMANT <b>Hospital Record, Olney, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Sub-Arachnoid Hemorrhage</b> DUE TO (b) <b>Arteriosclerosis, Genl</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>MAY 9, 1957</b> , to <b>MAY 15, 1959</b> , that I last saw the deceased alive on <b>MAY 15, 1959</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Jack A. Schumacher</b>				ADDRESS (Street, city or town, state) <b>105 Russell Ave., Gaithersburg, Md.</b>			
DATE SIGNED <b>5/16/59</b>				DATE SIGNED <b>5/16/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5-23-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Freedom</b>	
22d. LOCATION (City, town, or county) <b>Gaithersburg, Md.</b>				22e. (State) <b>Md.</b>		22f. (Country) <b>U.S.A.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frederic A. Spigel</b>				ADDRESS <b>Gaithersburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>				24c. (City, town, or county) <b>Gaithersburg, Md.</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5799

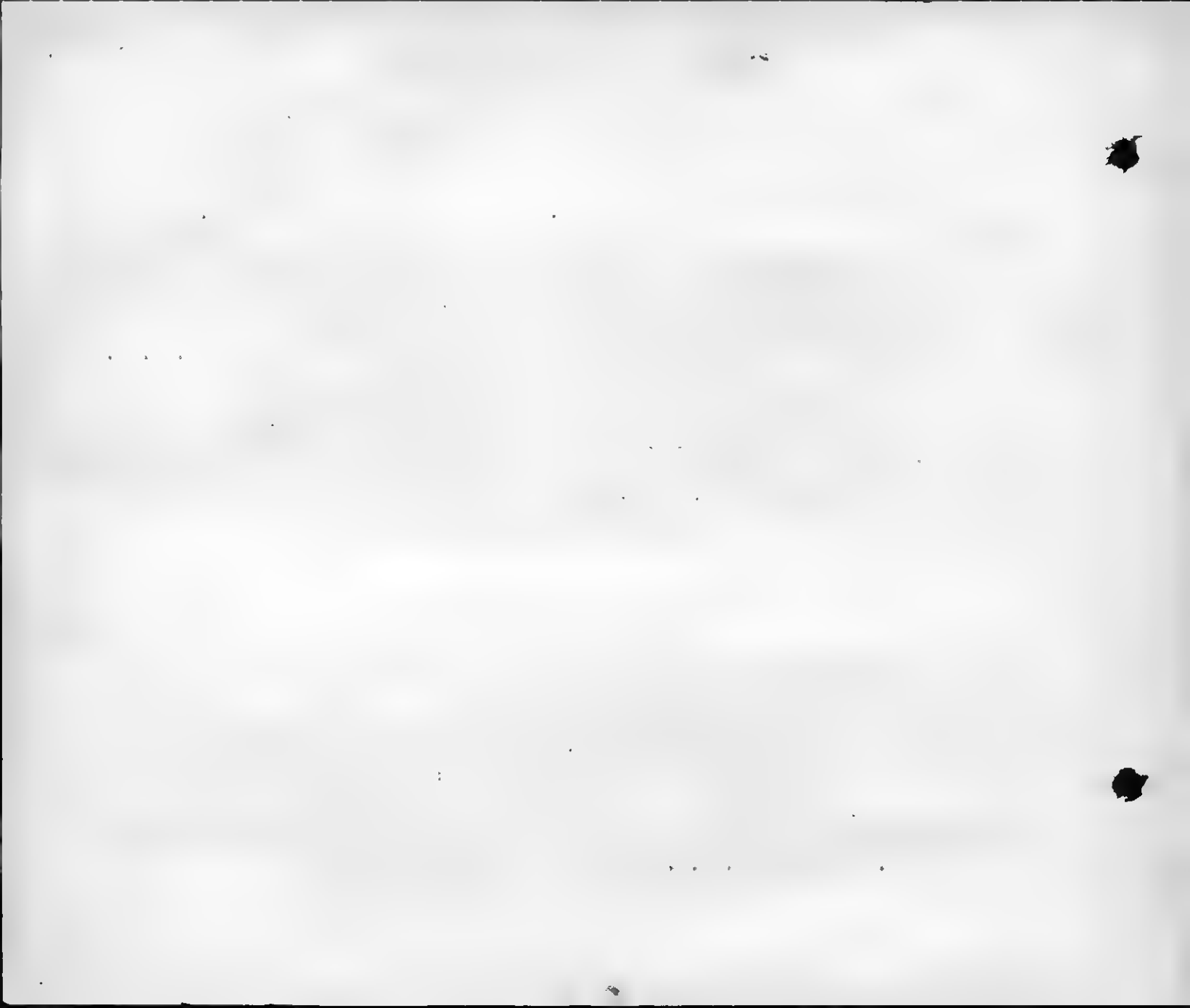
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>54 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			d. STREET ADDRESS <u>3100 Connecticut Avenue, N. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Margaret</u> Last <u>Laffin</u>			4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>19 59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 26, 1887</u>		9. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Theodore Ballering</u>			14. MOTHER'S MAIDEN NAME <u>Isabelle Wittman</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>390-20-8845</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the Breast Metastatic to Lung</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>2 Years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 19</u> , 19 <u>59</u> , to <u>May 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 12</u> , 19 <u>59</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>5/12/59</u> <u>The National Institutes of Health</u> <u>Bethesda 14, Maryland</u>					
ACTUAL <u>G. Richard Lee</u> M.D. <u>The Clinical Center</u> <u>5/12/59</u>					
PHYSICIAN'S NAME (Type) <u>G. RICHARD LEE, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	
22d. LOCATION (City, town, or county) (State) <u>WASH.</u> <u>D.C.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Noulton - 3831-GA. AVE. NW</u>			24a. REC'D BY REGISTRAR DATE <u>MAY 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5800

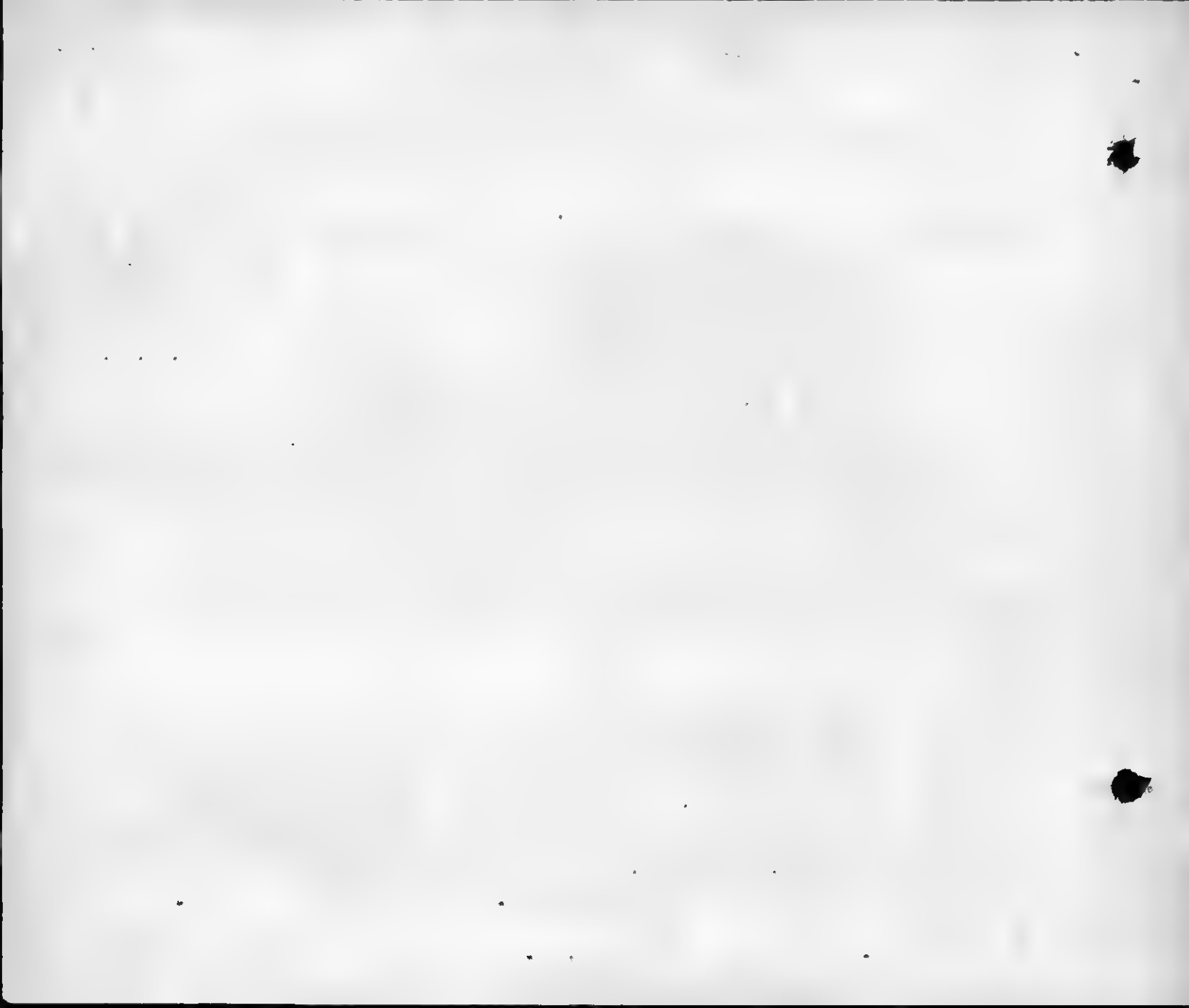
## CERTIFICATE OF DEATH

05784

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>17 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Tennessee</b> b. COUNTY <b>Erwin</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>77x -</b> d. STREET ADDRESS <b>Willow Street Extended</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert William Lawson, Jr.</b>				4. DATE OF DEATH Month Day Year <b>May 22, 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 19, 1917</b>	
9. AGE (In years last birthday) <b>42 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice-President</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturing</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>							
13. FATHER'S NAME <b>Robert W. Lawson, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Lettie Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO. <b>410-03-2610</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage of pontine cerebellar angle</b> <b>190.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malignant melanoma &amp; metastases to brain, adrenal gland</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Erwin</b>				20g. (County) <b>Tenn.</b>		20h. (State) <b>Tenn.</b>	
21. I certify that I attended the deceased from <b>May 5</b> , 19 <b>59</b> , to <b>May 22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 22</b> , 19 <b>59</b> , and that death occurred at <b>10:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5-23-59</b>							
ACTUAL SIGNATURE <b>James M. Marsh</b> M.D. <b>JAMES M. MARSH, M.D.</b>				PHYSICIAN'S NAME (Type) <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>				22b. DATE OF INTERMENT <b>5/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen</b>	
22d. LOCATION (City, town, State) <b>Erwin, Tenn.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fink</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician after this certificate has been signed by the attending physician and completely filled in by the registrar. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5801 CERTIFICATE OF DEATH

Reg. Dist. No. 05785

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Tazewell</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jewell Ridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>(none)</b>	
3. NAME OF DECEASED (Type or print) First <b>Nancy</b> Middle <b>Lee</b> Last <b>Layne</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>19 59</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 15, 1948</b>
9. AGE (In years last birthday) <b>10 yrs.</b>		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Arlin Layne</b>		14. MOTHER'S MAIDEN NAME <b>Lola Browning</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b> <b>754.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Hypertension.</b> (c) <b>Congenital Heart Disease with Ventricular Septal Defect, Post-Operative.</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 25, 19 59</b> to <b>May 10, 19 59</b> , that I last saw the deceased alive on <b>May 10, 19 59</b> , and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William P. Cornell</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>5/11/59</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM P. CORNELL, M.D.</b>		<b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>5/12/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>--</b>	22d. LOCATION (City, town, or county) (State) <b>Man, West Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co.-2901 14th St., N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 12 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
SM 2-57

FOR STATE  
HEALTH DEPT.

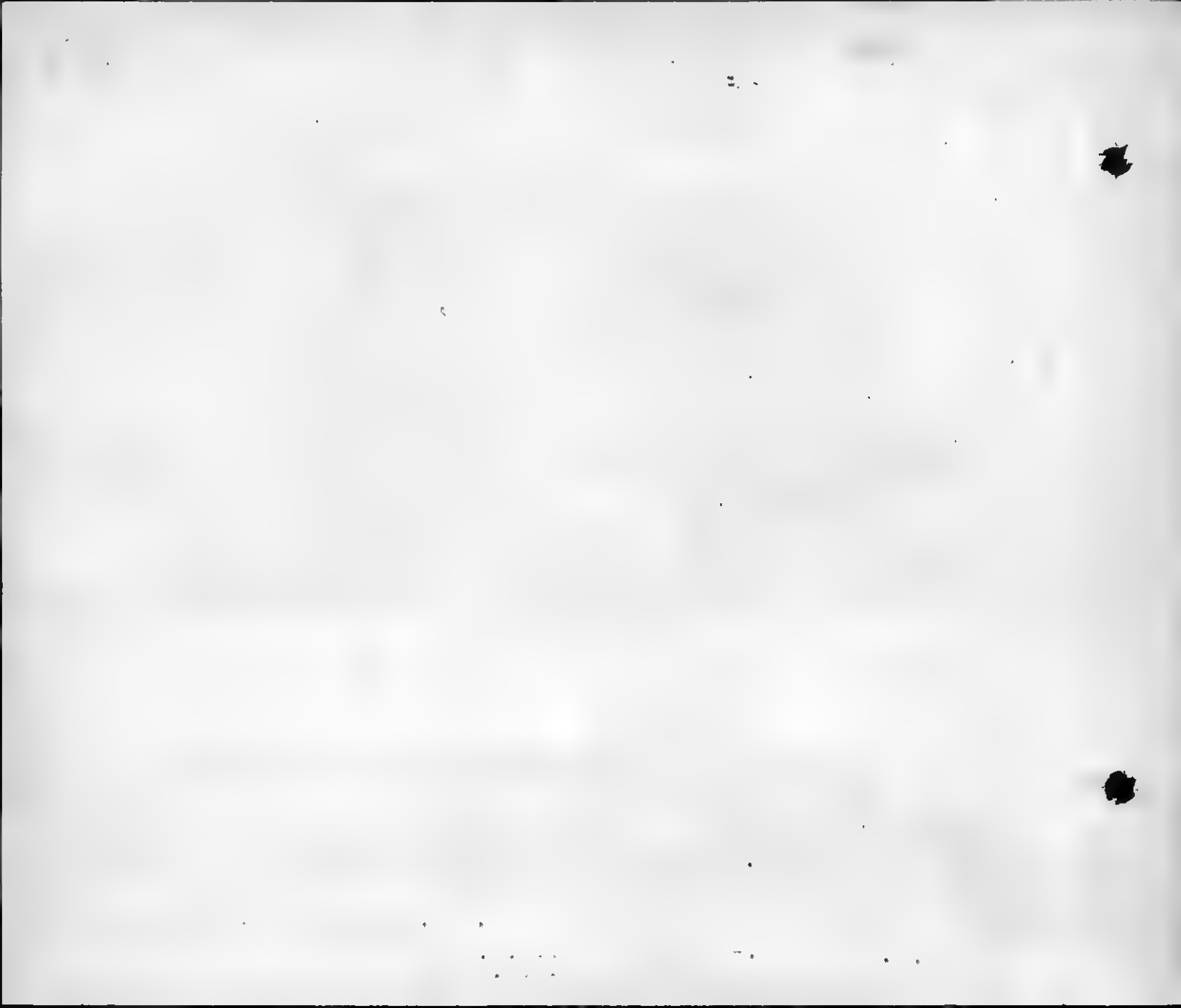
5716

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
c. LENGTH OF STAY IN 1b			d. STREET ADDRESS <u>Burnt Mills Hills</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>John Gordon Lee</u>			4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>1959</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>June 7, 1902</u>		9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Hospital Record</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>					
420.1 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Occlusion</u>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Merrill M. Cross</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5/9/59</u>	
EXAMINER'S NAME (Type) <u>Merrill M. Cross</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL CREMATION REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>	
22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>MAY 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>					



Patient had been receiving treatment in the Out-Patient Department of the Clinical Center of the National Institutes of Health, Bethesda 14, Maryland.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

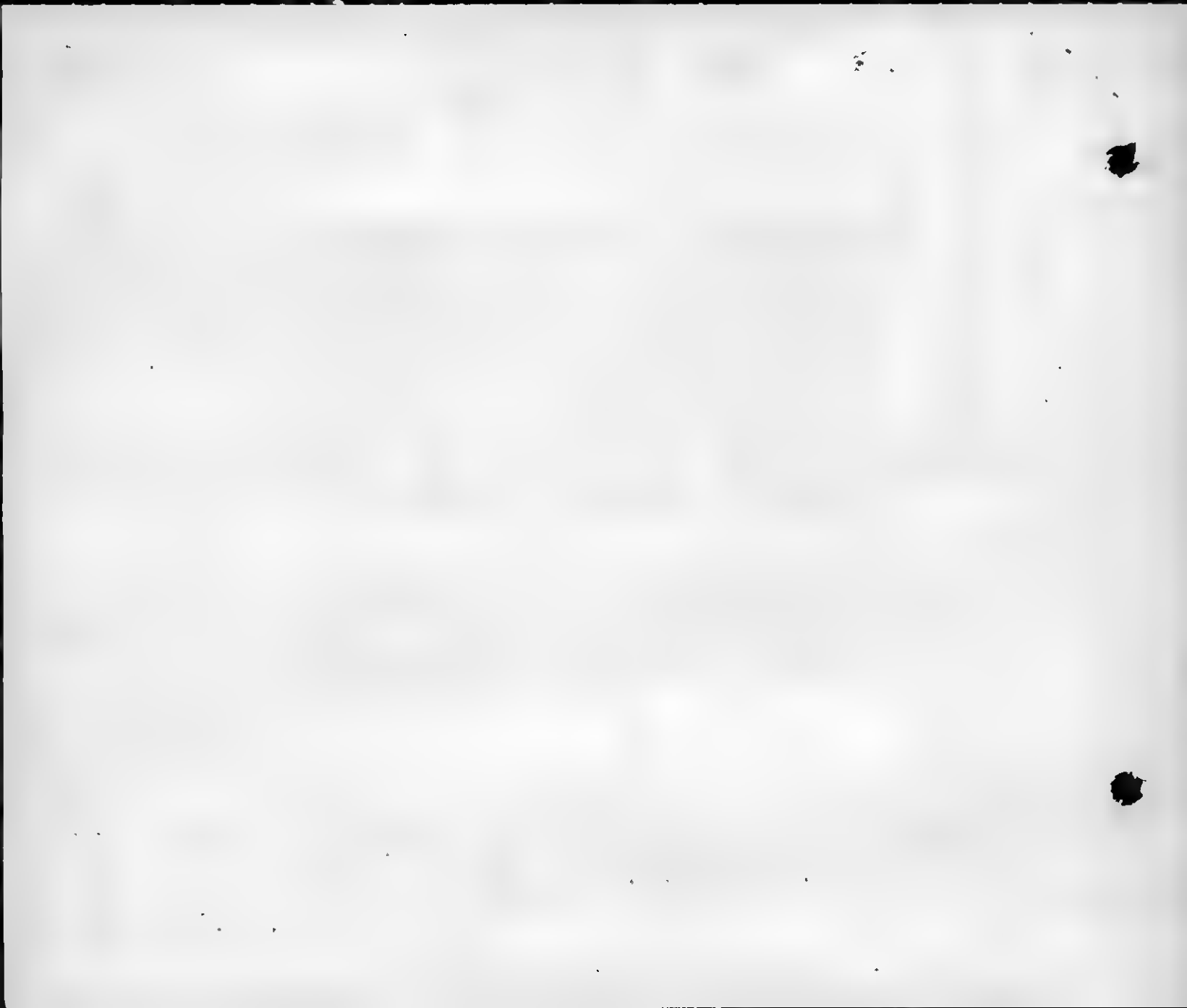
5802

## CERTIFICATE OF DEATH

Reg. Dist. No.

05787

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>43 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>X 120 Center Drive</b>			2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Aynor</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>77 x - 3</b> d. STREET ADDRESS <b>No Street Address</b> • IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Patrick Lewis</b>			4. DATE OF DEATH Month Day Year <b>May 2, 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 17, 1876</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>			13. FATHER'S NAME <b>Daniel Lewis</b>		
14. MOTHER'S MAIDEN NAME <b>Sarah Carmichael</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>Unascertainable</b>			17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Emboli and Infarction</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Unknown</b> INTERVAL BETWEEN ONSET AND DEATH Days Years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>March 20, 1959</b> , to <b>May 2, 1959</b> , that I last saw the deceased alive on <b>May 2, 1959</b> , and that death occurred at <b>4:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The National Institutes of Health 5-2-59</b> <b>Bethesda 14, Maryland</b>					
ACTUAL SIGNATURE <b>Robert M. Farrier, M.D.</b>			PHYSICIAN'S NAME (Type) <b>Robert M. Farrier, M.D.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit 5/2/59</b>		22b. DATE THEREOF <b>5/2/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Conway, So. Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>			24a. REC'D BY REGISTRAR <b>MAY 5 '59</b>		
ADDRESS <b>Bethesda, Maryland</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

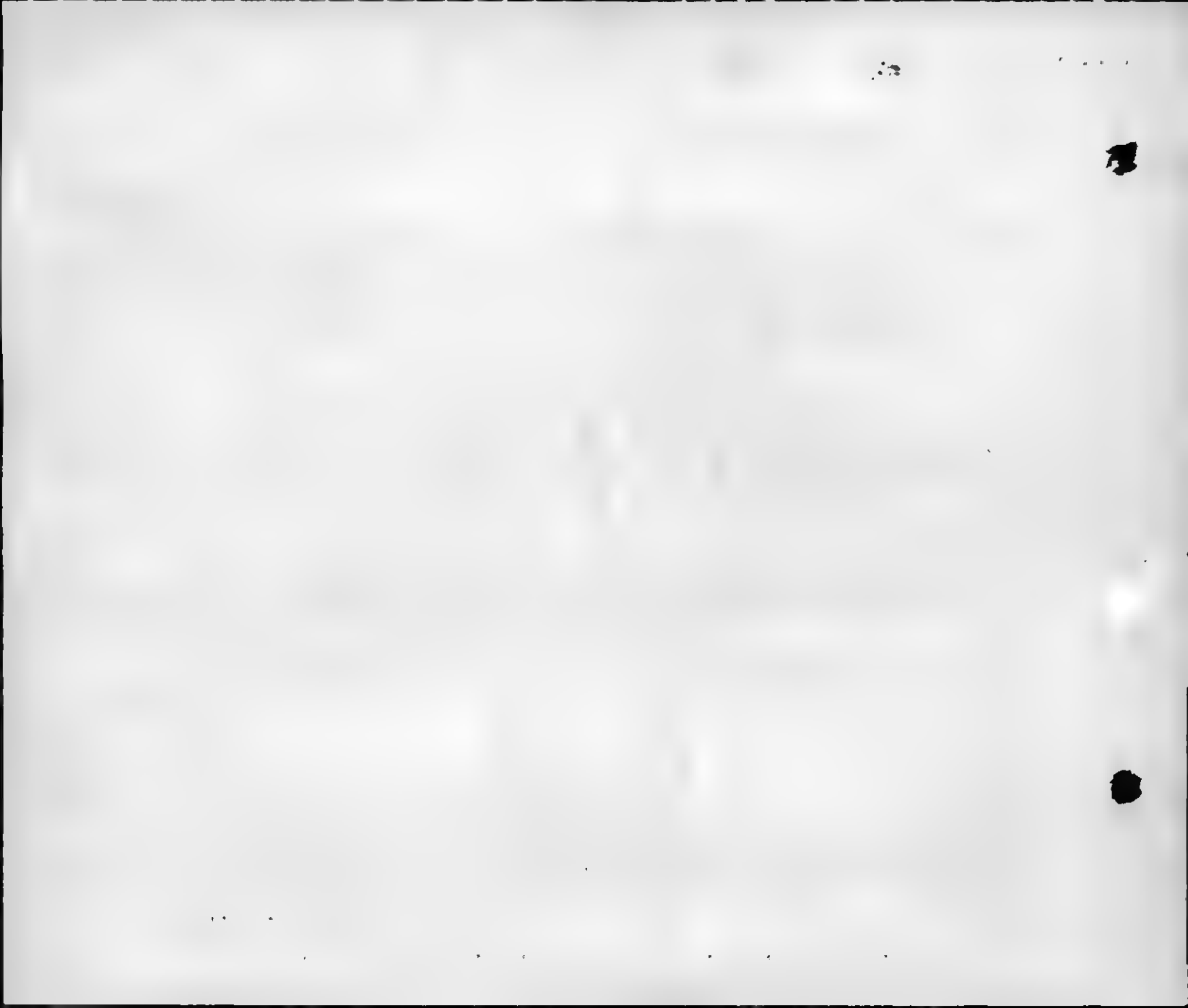
05788

5804

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2112 Dexter Avenue</u>			d. STREET ADDRESS <u>2112 Dexter Ave</u> 103		
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Fort</u> Last <u>Lightfoot</u>			4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1954</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28 1916</u>		9. AGE (In years last birthday) <u>38</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receiving Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>	
13. FATHER'S NAME <u>James Madison Lightfoot</u>			14. MOTHER'S MAIDEN NAME <u>Louise Susan Pittman</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>054-09-0544-1 JAMES R. LIGHTFOOT</u>		17. INFORMANT <u>Isaac R. Lightfoot</u> Address <u>1540 Greenview Dr. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Brain Hemorrhage</u> DUE TO (c) <u>Hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 31</u> p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 21, 1954</u> to <u>July 21, 1954</u> , that I last saw the deceased alive on <u>May 21, 1954</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>Edward J. Nicholas</u> M.D. <u>10114 Georgia Ave. Silver Spring, Md.</u>					
PHYSICIAN'S NAME (Type) <u>Edward J. Nicholas M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>			ADDRESS <u>SILVER SPRING, MD.</u>		
24a. REC'D BY REGISTRAR <u>DATE JUN 2 '59</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

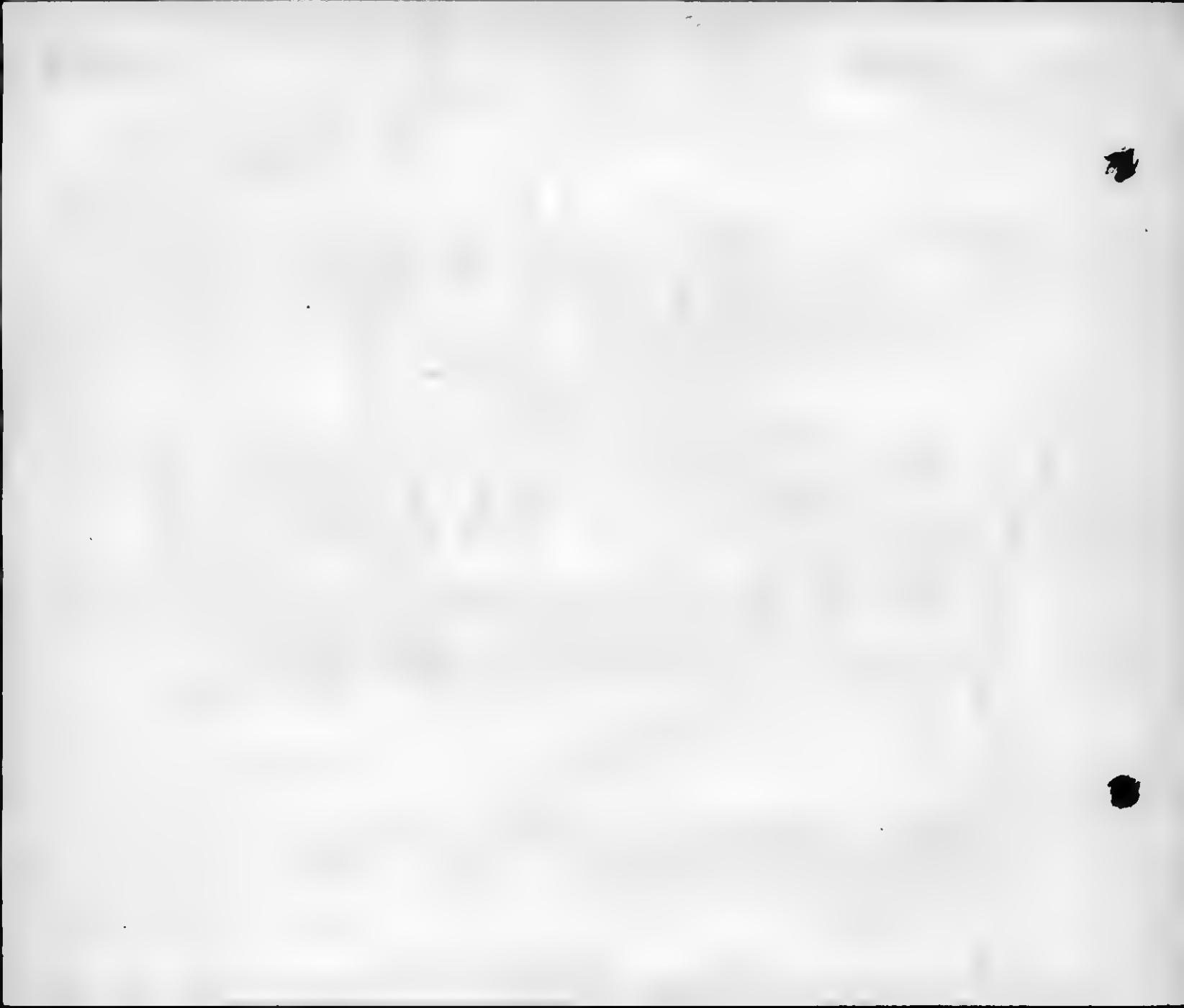
5805

Reg. Dist. No. 05789

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write P.O.A. and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3701 Cardiff Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Zacharias Bernard Lloyd Jr.</u>				4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-1914</u>	9. AGE (In years last birthday) <u>44</u> yrs	10. IF UNDER 1 YEAR Months <u>4</u> Days <u>22</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zacharias Bernard Lloyd</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Hanner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>1-1-1-1-1-1-1-1-1-1</u>		17. INFORMANT <u>Catharine Lloyd (wife)</u>		Address <u>Stim 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u>							
(c) <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yrs</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5-22-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASH., D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JAMES T. RYAN, INC.</u>				ADDRESS <u>517 PENNA. AVE SE WASH. D.C.</u>			
24a. REC'D BY REGISTRAR <u>MAY 25 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hearn</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



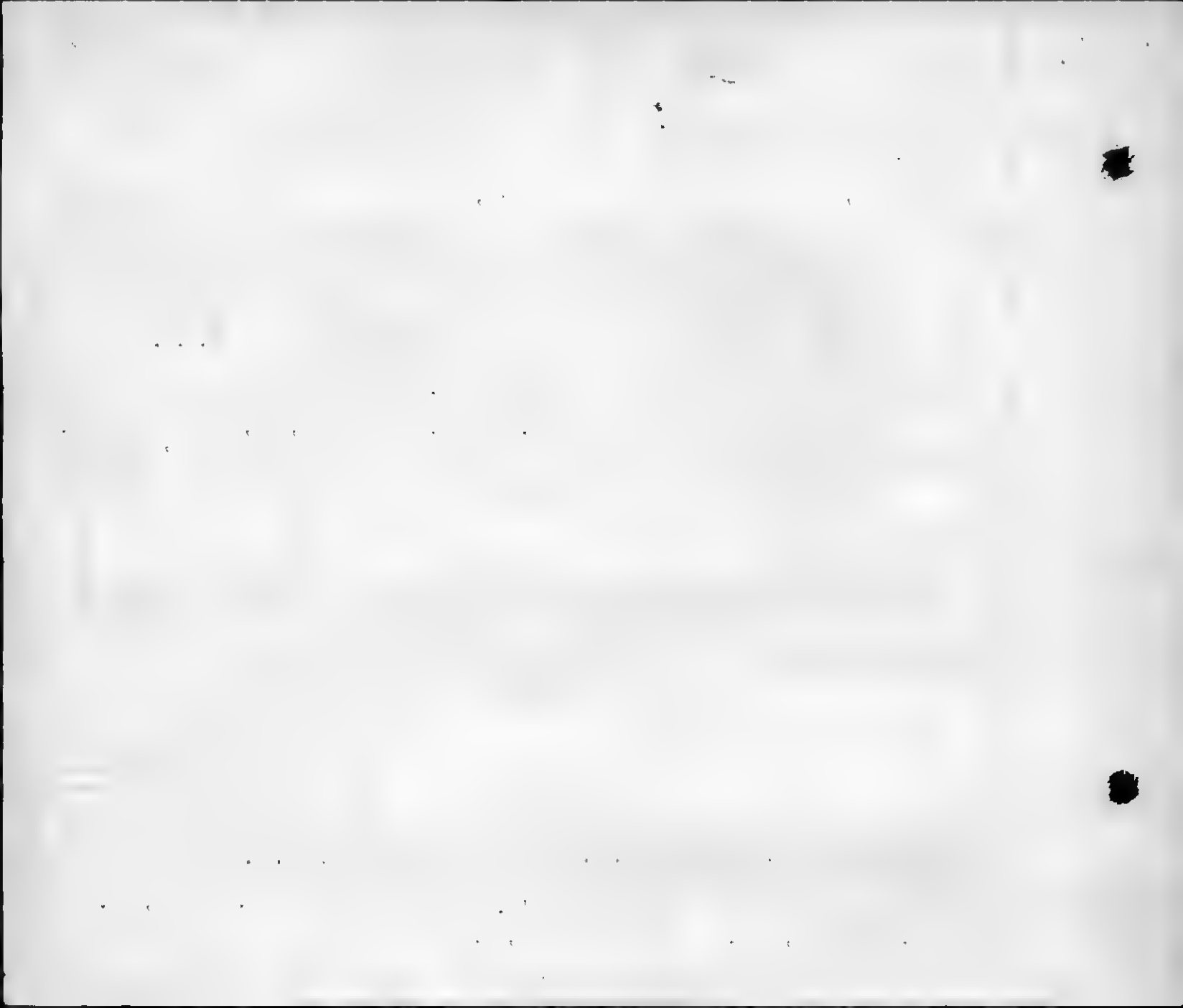
5727 CERTIFICATE OF DEATH

05790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		c. LENGTH OF STAY IN 1b <b>4 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12,715 CALDWELL STREET</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>	
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>VIRGINIA</b> Last <b>LOVEL</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/3/1900</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Brown</b>		14. MOTHER'S MAIDEN NAME <b>Laura V. Barrett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Mary C. Van Sickler</b>		Address <b>12,715 Caldwell St. Rockville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>200.1</b> IMMEDIATE CAUSE (a) <b>Lymphosarcoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 20, 1958</b> to <b>May 1, 1959</b> , that I last saw the deceased alive on <b>April 25, 1959</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Washington, D.C.</b> DATE SIGNED <b>5/2/59</b>			
ACTUAL SIGNATURE <b>Harold L. Hirsh</b> M.D. <b>635 Mass Ave N.W., DC</b>		PHYSICIAN'S NAME (Type) <b>Harold L. Hirsh, M.D.</b> <b>Washington, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/4/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON NAT'L. CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Geo. County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Jaska</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 5 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



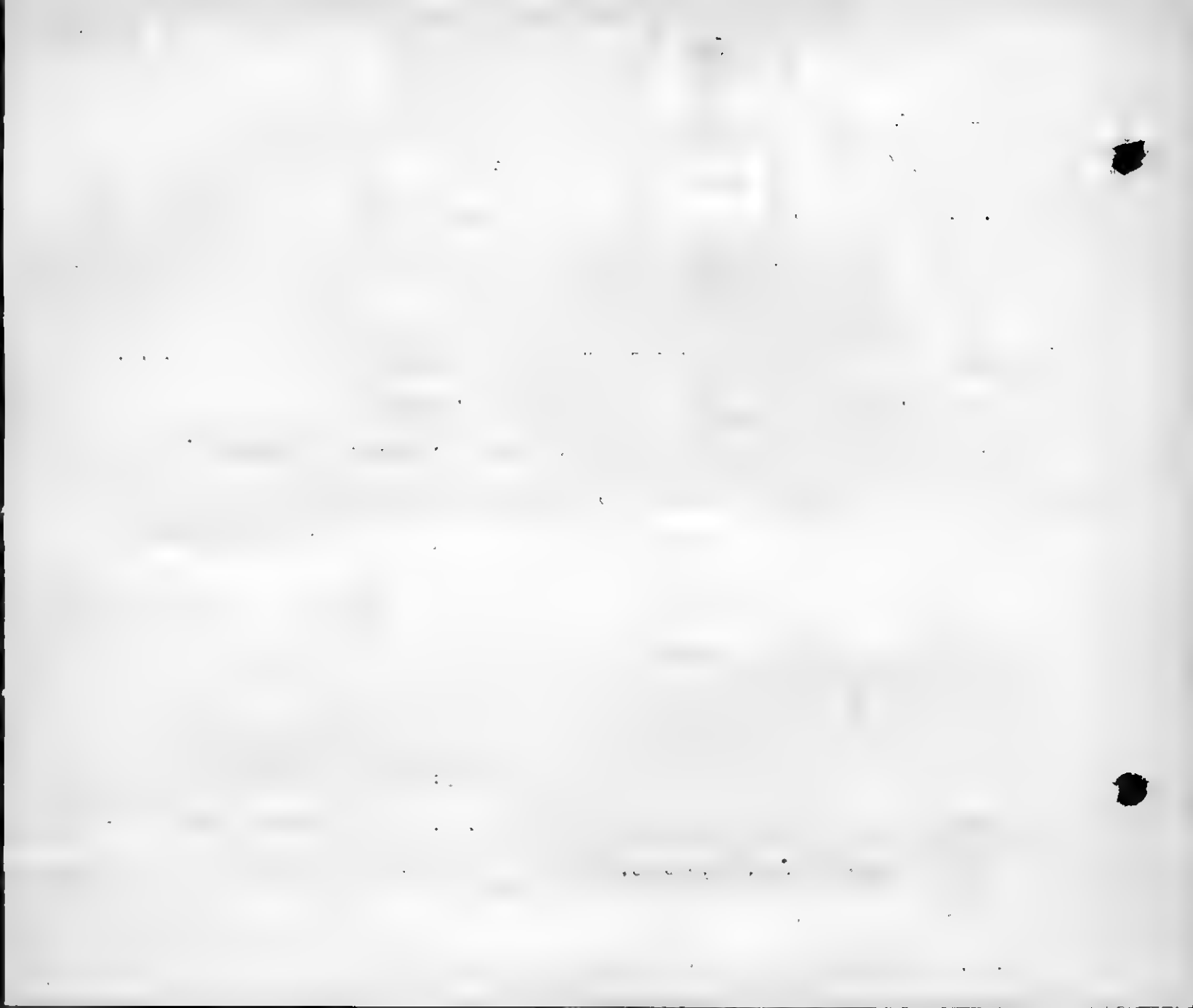
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5806 CERTIFICATE OF DEATH

05791

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>6 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Dover</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dover</b> d. STREET ADDRESS <b>1065B 3rd Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Ross</b> Last <b>MADRY</b>				4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-7-57</b>	
9. AGE (In years last birthday) <b>1</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James A. MADRY</b>				14. MOTHER'S MAIDEN NAME <b>Joy D. DECELL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>(F) James A. Madry, samw as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarctions, adrenal &amp; other organs</b> <b>754.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congenital Heart Disease (Ventricular Septal Defect)</b> DUE TO (c) <b>Advanced pulmonary Hypertension</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 10</b> , 19 <b>59</b> , to <b>May 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 16</b> , 19 <b>59</b> , and that death occurred at <b>9:30A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Kenneth W. Sell</b>		ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b>				DATE SIGNED <b>5-16-59</b>	
PHYSICIAN'S NAME (Type) <b>Kenneth W. Sell, Lt, MC, USN</b>		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		22b. DATE THEREOF <b>5-17-59</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Dover Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				ADDRESS <b>Funeral Home, Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 19 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5807

## CERTIFICATE OF DEATH

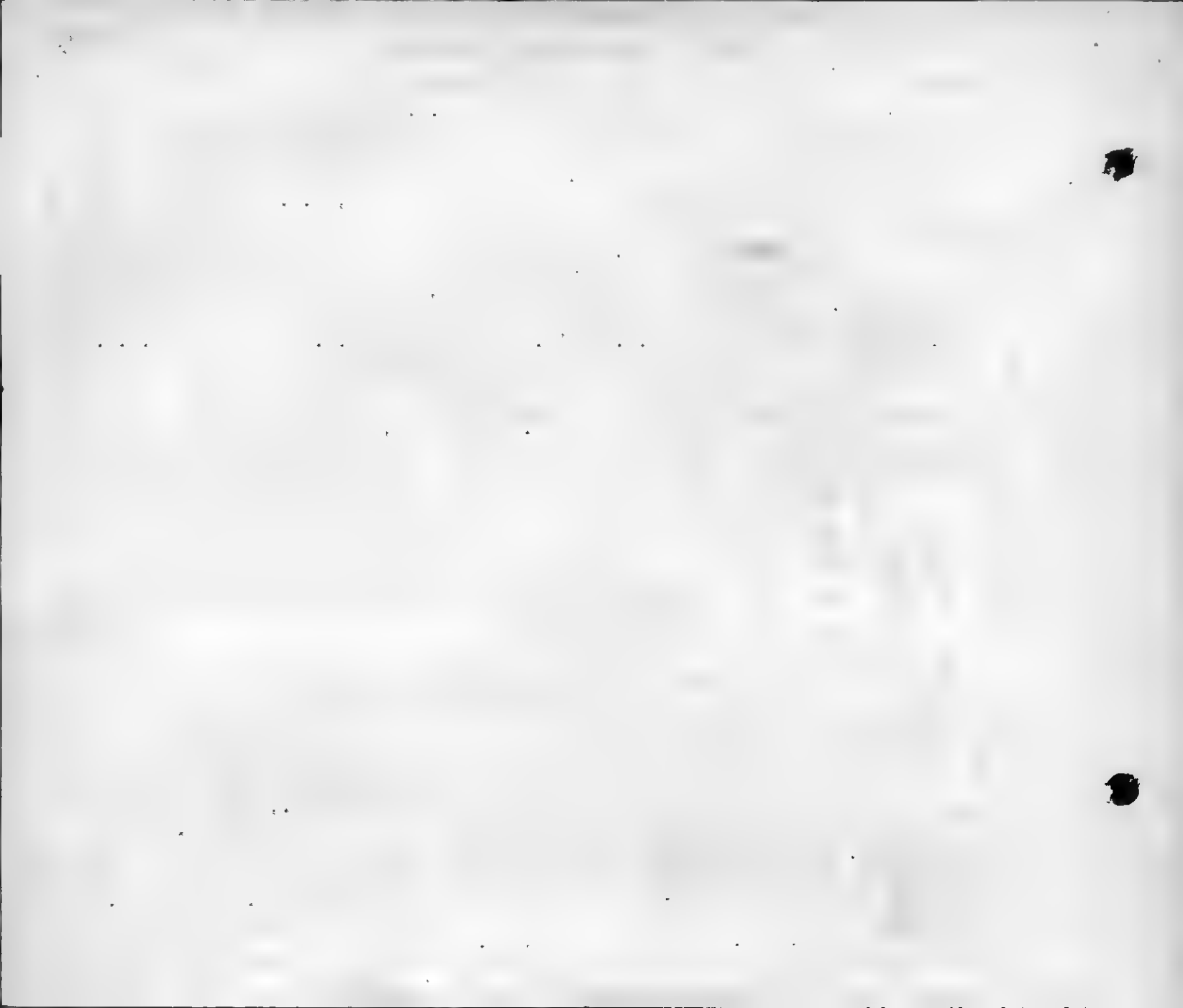
05792

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> <b>41X</b>		d. STREET ADDRESS <b>1920 S Street, N.W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS REST HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>CLARE</b> Last <b>MARTIN</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-Stenographer (retired) U.S. GOV'T.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM MARTIN</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET KOCH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>yes</b>	
17. INFORMANT Address <b>Mrs. Sarah King, Leonardtown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 13, 1959</b> , to <b>May 13, 1959</b> , that I last saw the deceased alive on <b>May 13, 1959</b> , and that death occurred at <b>6:30 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9241 Columbia Blvd., Silver Spring, Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>J. Marion Bankhead</b>		PHYSICIAN'S NAME (Type) <b>J. MARION BANKHEAD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	22b. DATE THEREOF <b>5/16/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 18 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

It was a Christian death. Had no medical attention while I was called about 4 hours prior to her death. Dr. Broadbent, Medical Director of K & H, was called.





1  
FOR STATE  
HEALTH DEPT.

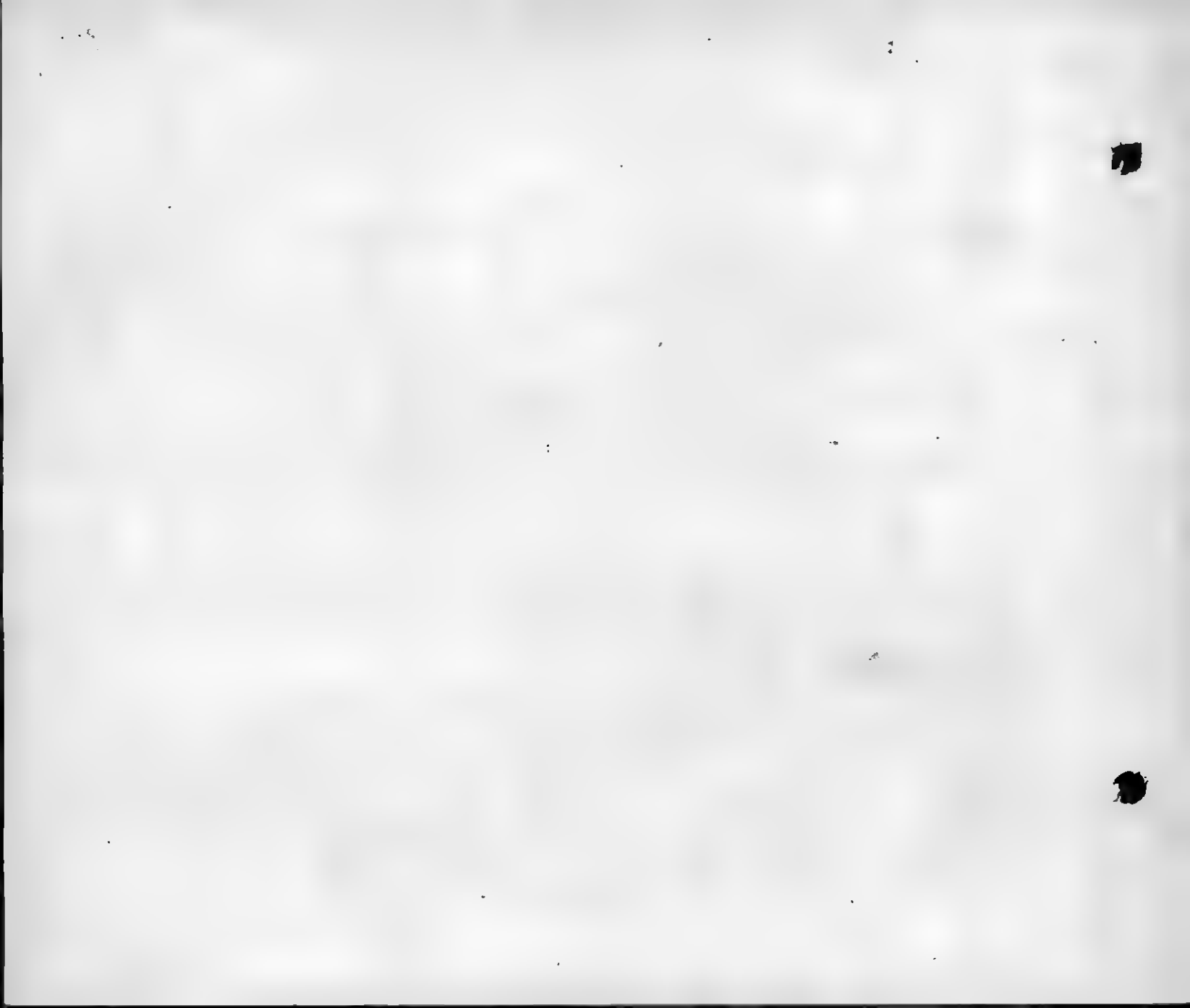
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5808 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05793

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4001 Underwood St</u>				e. STREET ADDRESS <u>4001 Underwood St</u>			
3. NAME OF DECEASED (Type or print) <u>Wayne Landry Martin</u>				4. DATE OF DEATH <u>May 14 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 15 1871</u>	
9. AGE (In years last birthday) <u>87</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <u>La.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
13. FATHER'S NAME <u>Ernest Landry</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>No</u>			
17. INFORMANT <u>Laurette Richter</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5-19-59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u> ADDRESS <u>2224 - Wis. Ave</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 18 '59</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

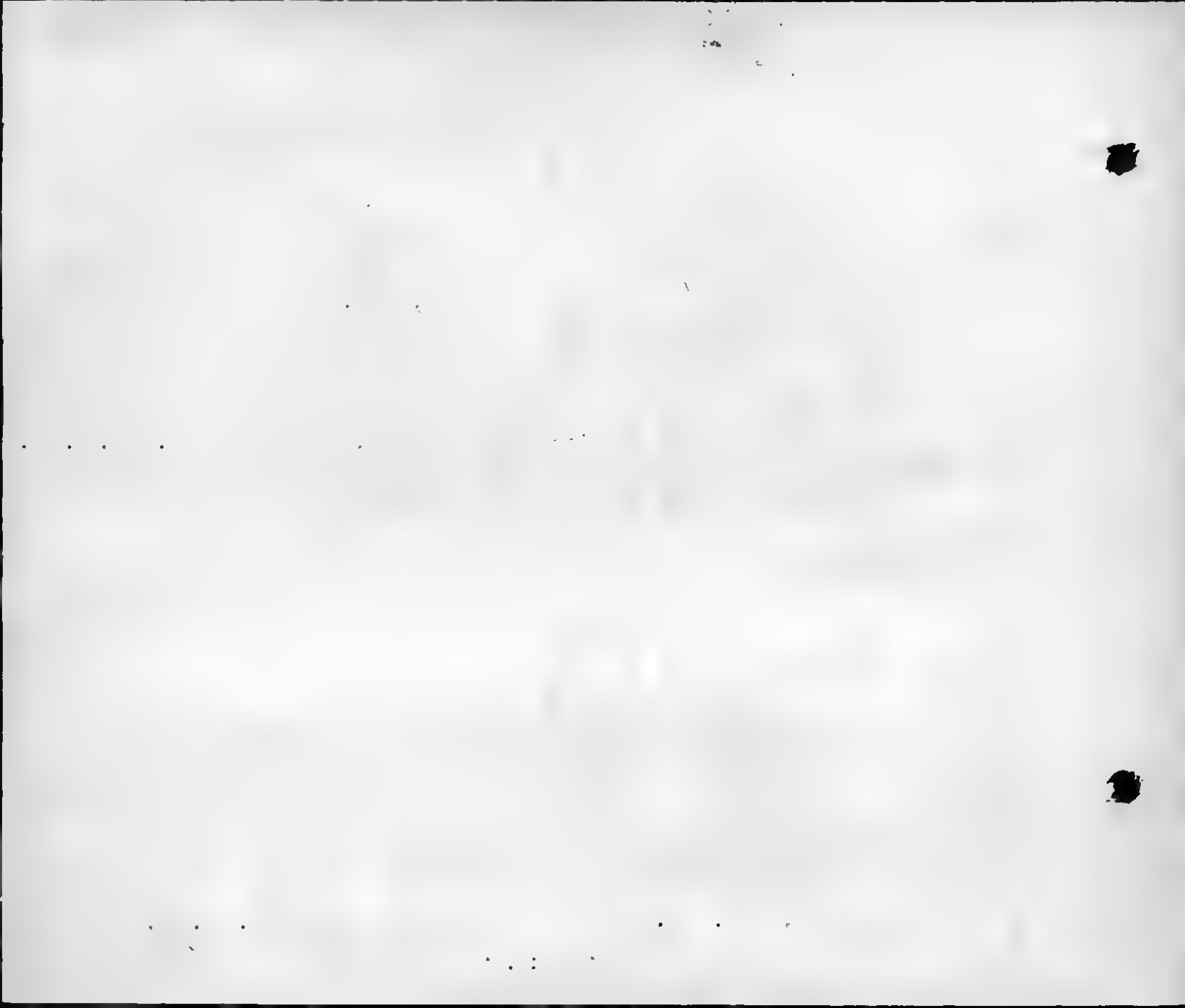
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5717 CERTIFICATE OF DEATH

05794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 Takoma Park</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8507 Flower Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>SIGNE</b> Last <b>MATTSON</b>				4. DATE OF DEATH Month <b>5</b> Day <b>21</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 27, 1892.</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Sweden</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Nils Petterson</b>				14. MOTHER'S MAIDEN NAME <b>Neilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Bror Walter Mattson, 8507 Flower Ave. Tak.Pk. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 55</b> to <b>May 1959</b> , that I last saw the deceased alive on <b>May 7 1959</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Bernard A Fitzgerald</b> M.D.				ADDRESS (Street, city or town, state) <b>217 University Blvd E Silver Spring, Md.</b>		DATE SIGNED <b>5-21-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 25, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg Rd. Pr Geo Co Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Kline</b>				24a. REC'D BY REGISTRAR <b>DATE MAY 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

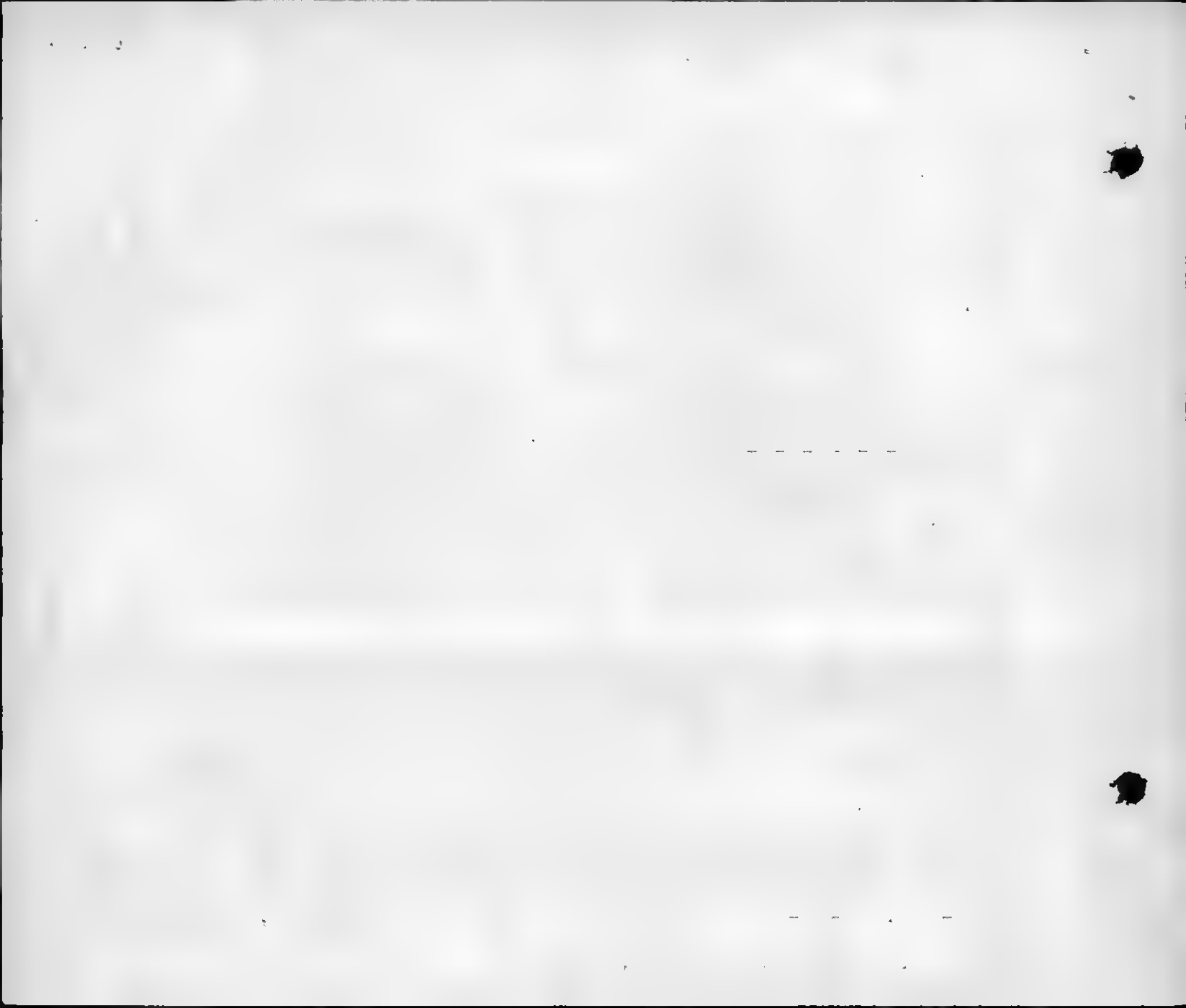
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

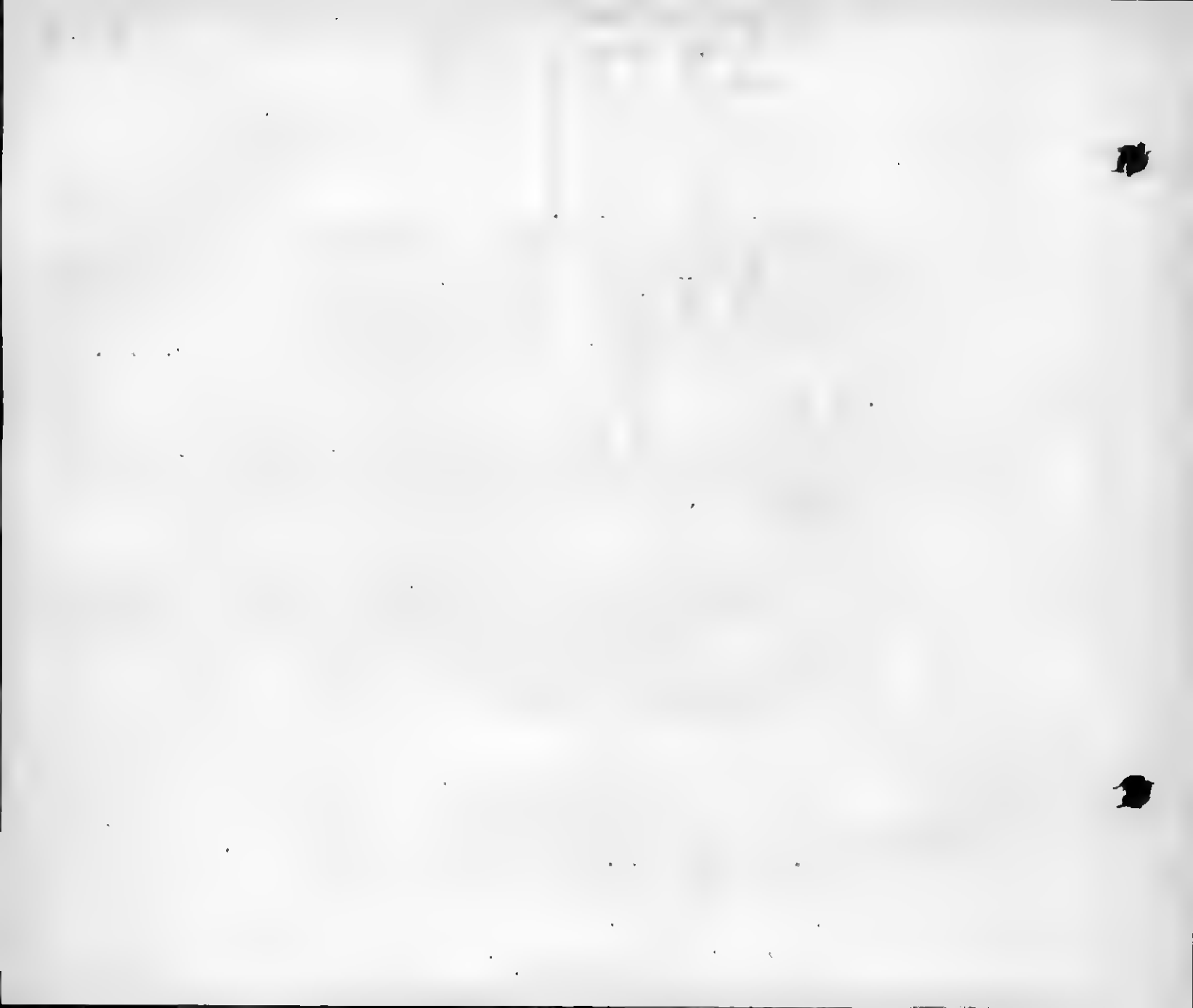
05795

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 14		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 14	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9120 Harrington Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ronald Eugene McAllister</u>		4. DATE OF DEATH <u>May 17 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-8-1863</u>
9. AGE In years last birthday <u>95</u>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>9</u> Hours <u></u> M.n. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>	
11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levi P. McAllister</u>		14. MOTHER'S MAIDEN NAME <u>Lorenda V. Lothrop</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Christine McAllister - Sister</u>		Address <u>2</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosehart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>May 17 1959</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Trans-Bur.</u>		22b. DATE THEREOF <u>5-20-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Winfield, Kansas</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>MAY 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Christian L. Klaus</u>	









FOR STATE  
HEALTH DEPT.

5811

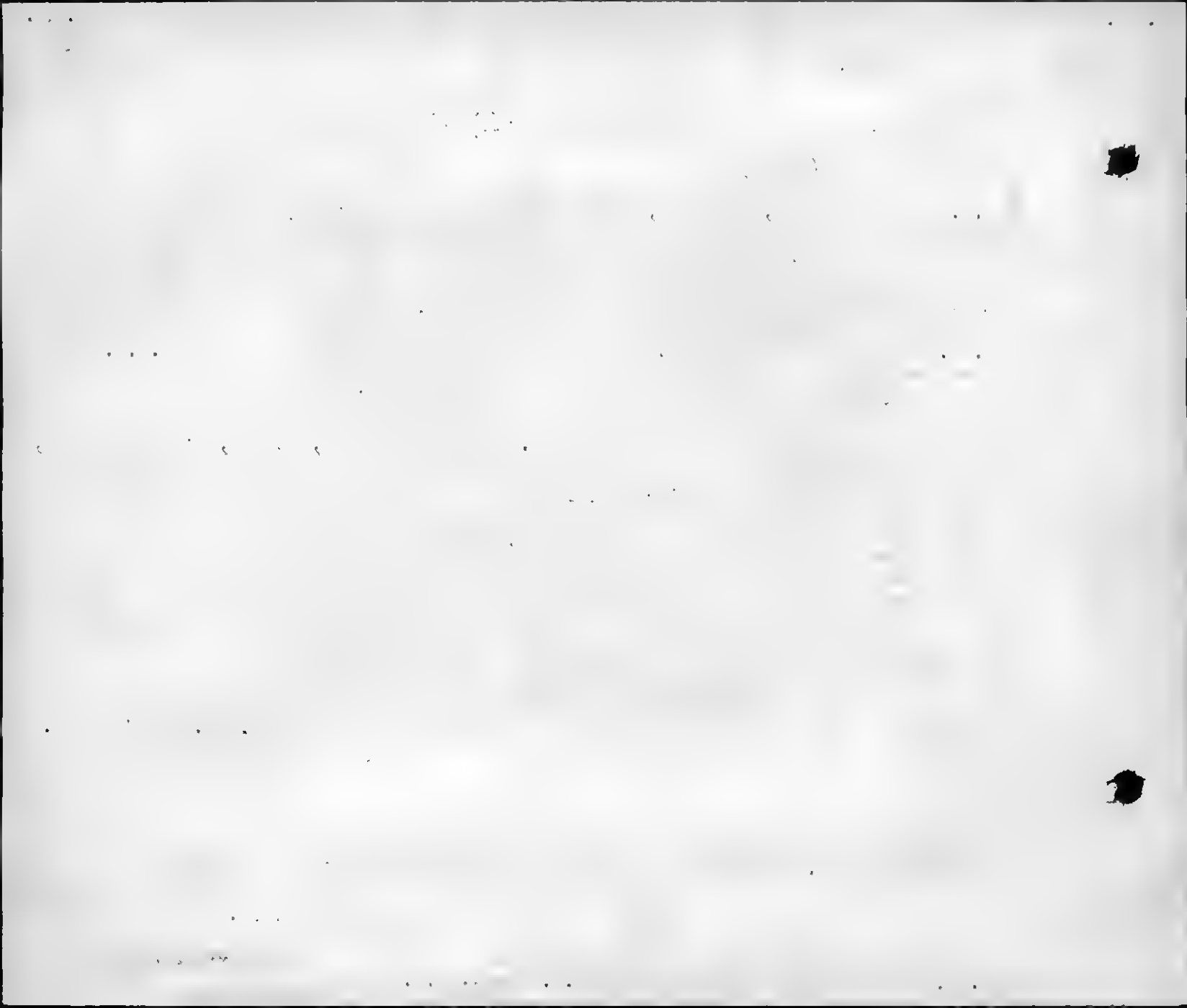
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05797

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norfolk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		d. STREET ADDRESS <b>1661 Banning Road</b>	
3. NAME OF DECEASED (Type or print) <b>Forest Hope MC CLANAN</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 28, 1919</b>
9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pilot</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hugh Hope MC CLANAN</b>		14. MOTHER'S MAIDEN NAME <b>Zelpha Wolf</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 1941-1959</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Wife</b>		Address <b>Mrs. Arlene MC CLANAN, Qtrs H, Patuxent River, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal hemorrhage</b> <b>860x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Multiple injuries, extreme</b> (c) <b>Helicopter accident</b> DUE TO (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Helicopter accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>1010 a.m. 5-22 19 59</b>		20d. INJURY OCCURRED While / Not while of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>NAS PAX RIV MD</b>		20f. (City or town) (County) (State) <b>Patuxent R. St. Mary's Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M D		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>25 May 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Norfolk, Va.</b>	
23. FUNERAL HOME		24a. REC'D BY REGISTRAR DATE <b>MAY 27 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

S. H. HINES COMPANY, 2901 14th St, N.W. Wash., D.C.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5812

CERTIFICATE OF DEATH

05798

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Ind.</u>				d. STREET ADDRESS <u>Guilford</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Jeffery</u> Last <u>McDonald</u>				4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4, 1959</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
		Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min <u>2</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>							
13. FATHER'S NAME <u>Chancey McDonald</u>				14. MOTHER'S MAIDEN NAME <u>Buby Genevieve Edwards</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atelectasis</u>							
762.5 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity (2# 2oz)</u>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 4</u> , 19 <u>59</u> , to <u>May 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 6</u> , 19 <u>59</u> , and that death occurred at <u>1:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.				DATE SIGNED <u>May 6, 1959</u>			
NAME (Type) <u>C. S. Whitaker, M. D., Clarksville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>		22d. LOCATION (City, town, or county) (State) <u>Guilford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>F.C. Higinbotham, Ellicott City, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

2073336 XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be kept and far use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 show be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



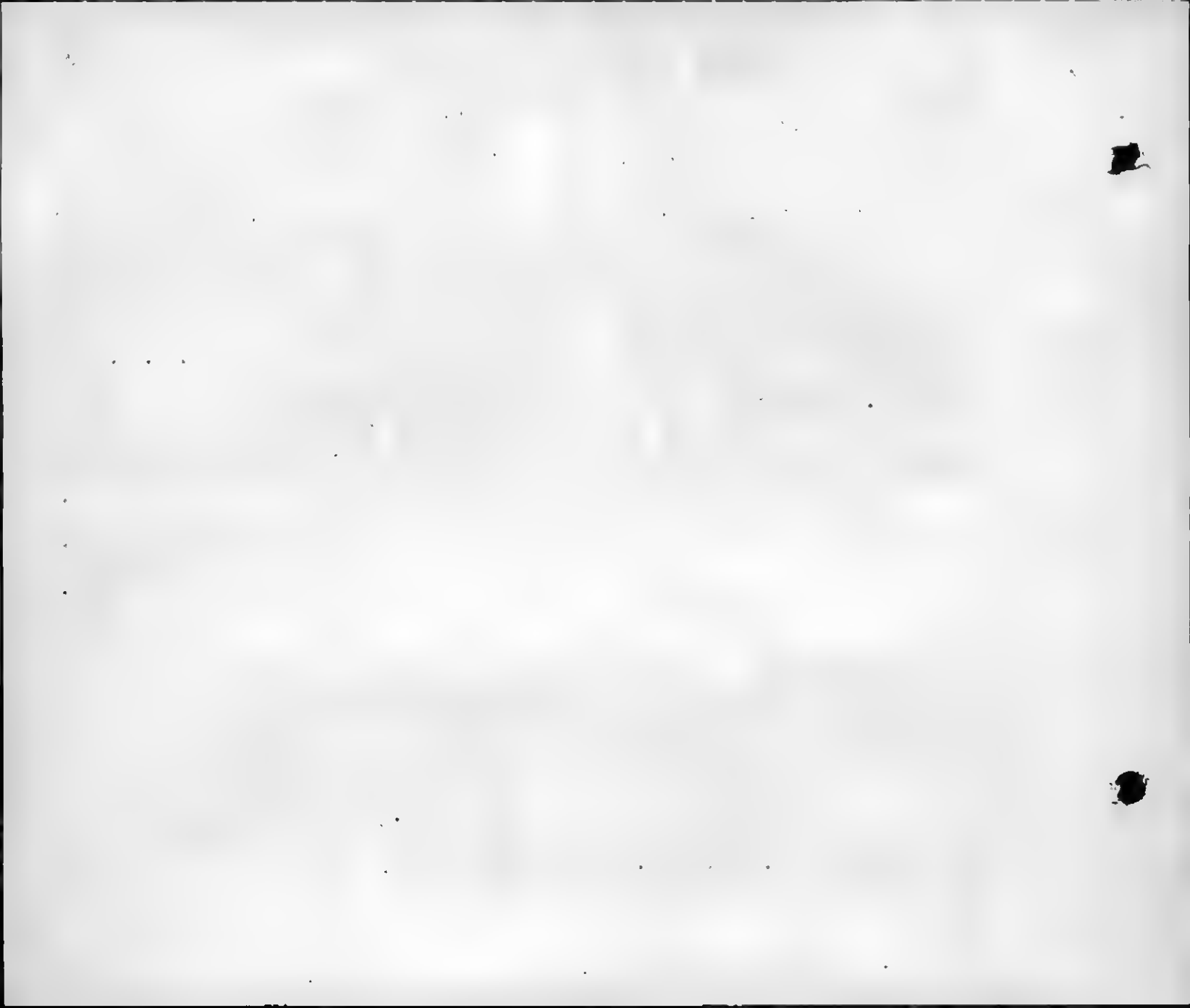
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5813 CERTIFICATE OF DEATH

05799

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Florida</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Smyrna Beach</b>	
c. LENGTH OF STAY IN TB <b>129 days</b>		d. STREET ADDRESS <b>616 North Orange Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nancy</b> Middle <b>Pearl</b> Last <b>Melvin</b>		4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 20, 1902</b>
9. AGE (In years last birthday) <b>56 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Caswell J. Richbough</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>43</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary infarcts</b> DUE TO (c) <b>Acute myelogenous leukemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>40 hrs.</b> <b>7 mos.</b> <b>11 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 28, 1958</b> to <b>May 6, 1959</b> , that I last saw the deceased alive on <b>May 6, 1959</b> and that death occurred at <b>11:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Richard H. Moy</i>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Richard H. Moy, M. D.</b>		DATE SIGNED <b>May 6, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>5-7-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kiana</i>			



5814

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Res' dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>W. Lanham Hills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>7759 Emerson Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Earl</b> Middle <b>Allison</b> Last <b>MERRYMAN</b>		4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 May 1901</b>
9. AGE (In years last birthday) yrs. <b>58</b>		10. IF UNDER 1 YEAR: Months <b>2</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Franklin Merryman</b>		14. MOTHER'S MAIDEN NAME <b>Maude Youngblood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>1921-1952</b>		16. SOCIAL SECURITY NO. <b>577-09-8904</b>	
INFORMANT <b>Mary Irene Merryman (wife)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MALNUTRITION &amp; INANITION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA COLON, RECURRENT, WITH</b> DUE TO (c) <b>METASTASES TO PERITONEAL &amp; PLEURAL ORGANS</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b> 6 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>25 May 1959</b> , 19 <b>59</b> , to <b>31 May 1959</b> , that I last saw the deceased alive on <b>31 May 1959</b> , and that death occurred at <b>10:25 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>F. S. Caldwell</b> M.D.			
PHYSICIAN'S NAME (Type) <b>F. S. CALDWELL LT MC USN</b>		U. S. Naval Hospital, Bethesda, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4 June 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>JUN 3 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6  
FOR  
HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

or its

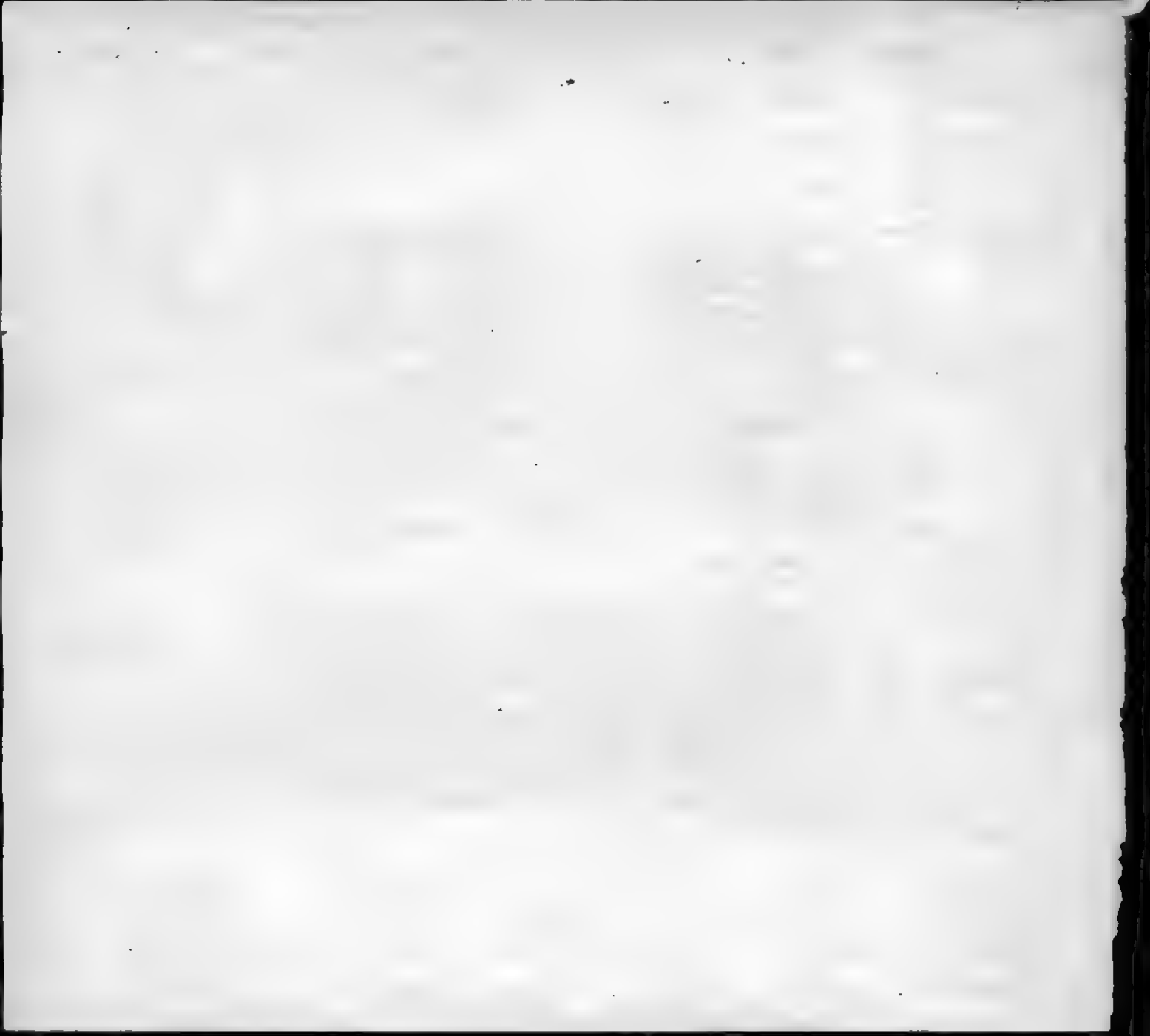
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SM 2/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05801

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6200 Verne St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Duncan Miller</u>		4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-1885</u>
9. AGE (In years last birthday) <u>74</u> yr		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>stenographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Duncan</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-30-7528B</u>	
17. INFORMANT <u>John Miller (son)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Thrombosis</u> <u>100.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fractured Rt hip</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell while crossing street</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. <u>3-21</u> 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Washington</u> (County) <u>dc</u> (State) <u>dc</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 3 '59</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

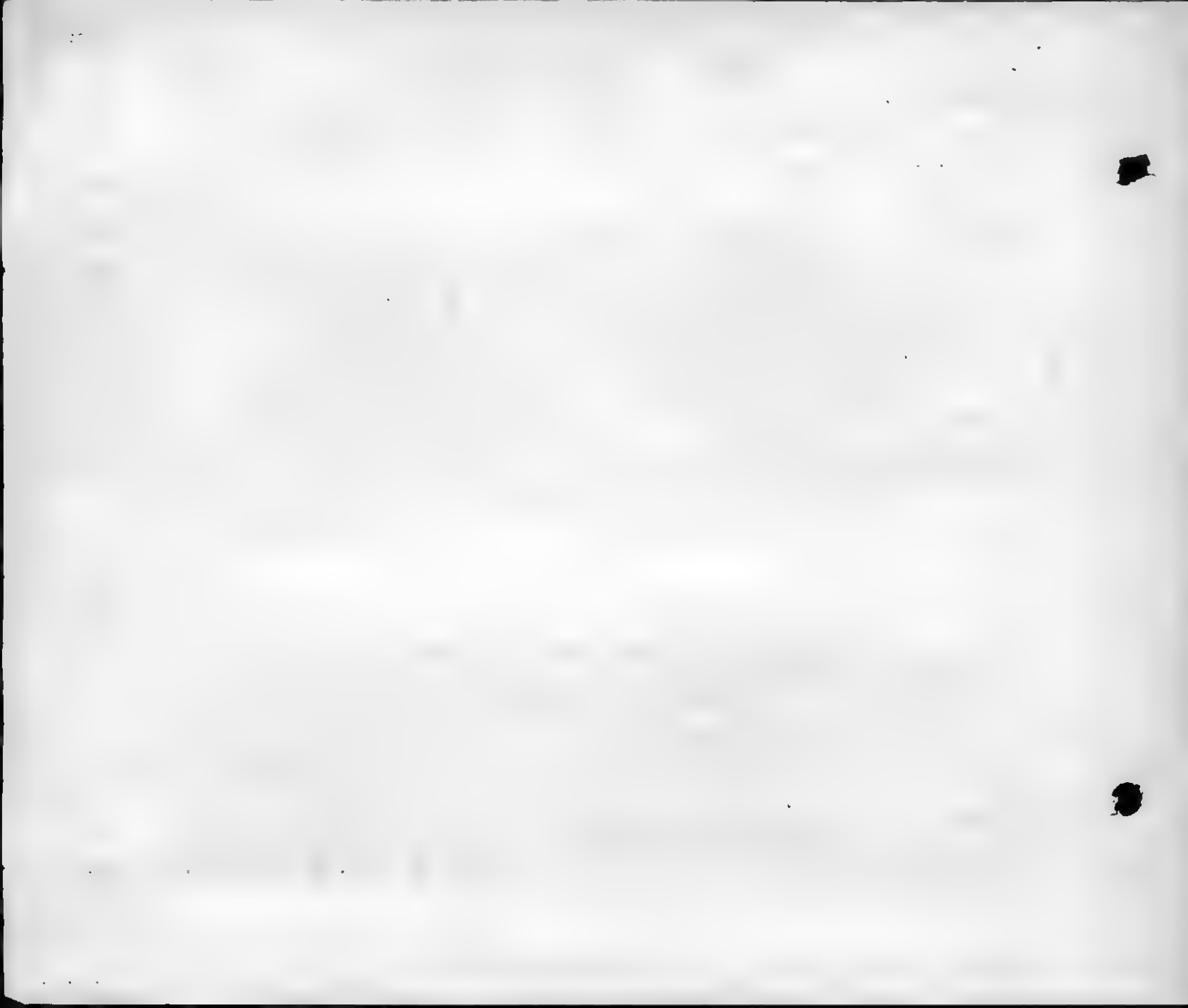


## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>DC</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>15 1/2 mos</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>		d. STREET ADDRESS <b>Washington</b>	
3. NAME OF DECEASED (Type or print) <b>May</b> First <b>T</b> Middle <b>Miller</b> Last		4. DATE OF DEATH <b>May</b> Month <b>29</b> Day <b>1959</b> Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 16, 1879</b>
9. AGE (In years last birthday) <b>80</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt</b>	
11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Jacob Ramming</b>		14. MOTHER'S MAIDEN NAME <b>Mary Riordon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs Ruth Blackburn</b>		Address <b>5028 Allan Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Stomach</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> 19 <b>53</b> to <b>May</b> 19 <b>59</b> , that I last saw the deceased alive on <b>May 28</b> 19 <b>59</b> , and that death occurred at <b>6:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1801 Eye St N.W. Wash. 6 D.C.</b> DATE SIGNED <b>M.H. Stolar M.D.</b>			
22a. DATE OF DEATH <b>5/30/59</b>			
22b. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>			
22c. LOCATION (City, town, or county) (State) <b>Southland, Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph M. Wilson</b> ADDRESS <b>1756 Penn. Ave. Wash</b>			
24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be designated for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

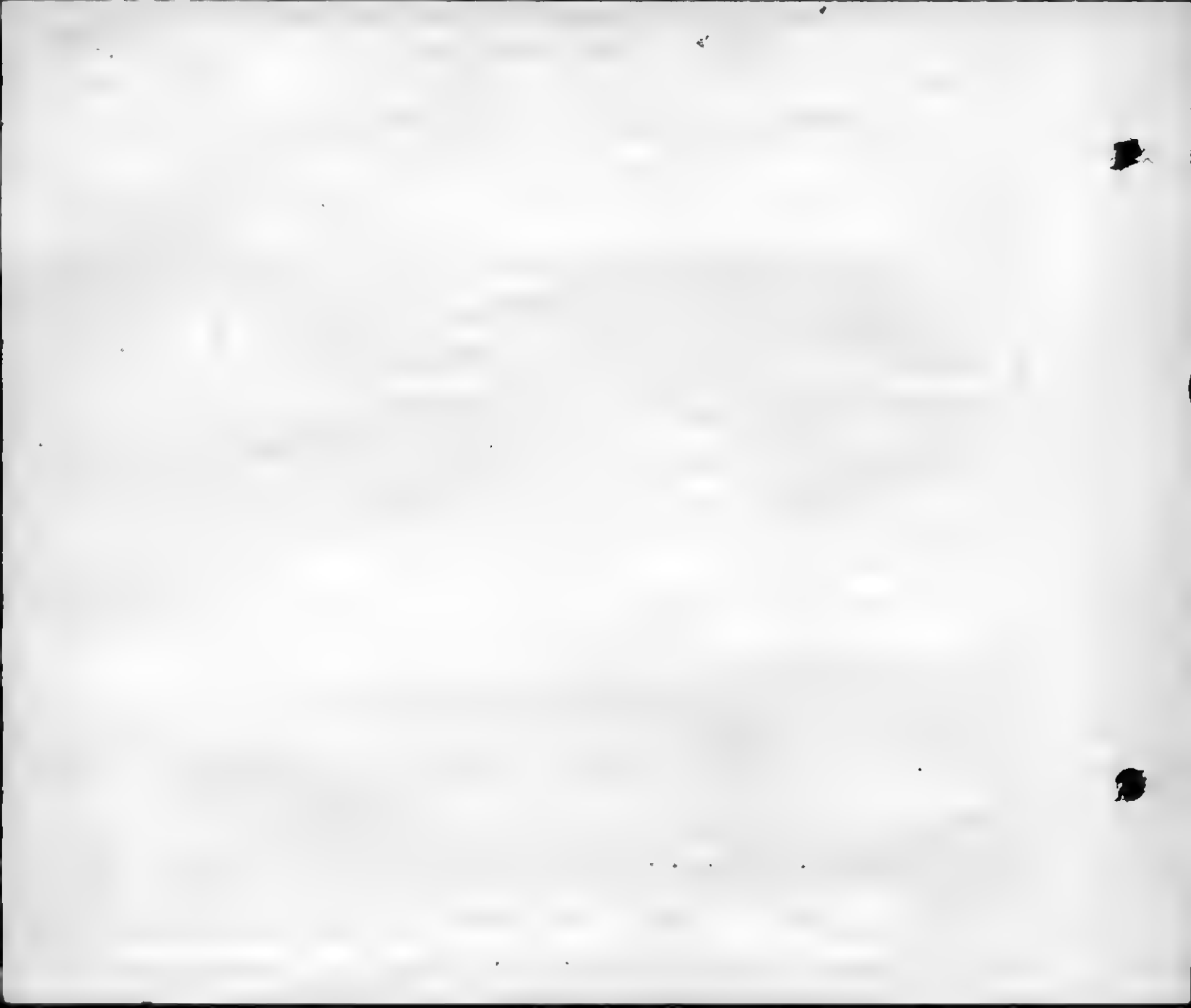
5817

## CERTIFICATE OF DEATH

05803

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE [Where deceased lived. If institution. Residence before admission] a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <b>Silver Spring</b>				c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <b>Silver Spring</b>			
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION <b>10104 Georgia Avenue</b>				d. STREET ADDRESS <b>10104 Georgia Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>VICTORIA</b> Middle Last <b>MONCHICK</b>				4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1892</b>	9. AGE [In years last birthday] <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE [State or foreign country] <b>Austria</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Louis Waschler</b>				14. MOTHER'S MAIDEN NAME <b>Fanny Higger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Louis Monchick 10104 Georgia Avenue, S.S., Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ATHEROSCLEROTIC HEART DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>@ 6 HRS</b> <b>18 MO</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CONGESTIVE HEART FAILURE</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY [Home, farm, factory, street, office bldg., etc.]	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>JAN 23</b> , 19 <b>59</b> , to <b>MAY 14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>MAY 14</b> , 19 <b>59</b> , and that death occurred at <b>1145 A.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Edward A. Beeman</b>				M.D. <b>10620 GEORGIA AVE</b>			
PHYSICIAN'S NAME (Type) <b>Edward A. Beeman, M.D.</b>				<b>SILVER SPRING, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-15-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baker Street Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Boston, Massachusetts</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Danzansky &amp; Sons-3501-14th St., N.W.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAY 18 '59</b>	
				24b. REGISTRAR'S SIGNATURE			



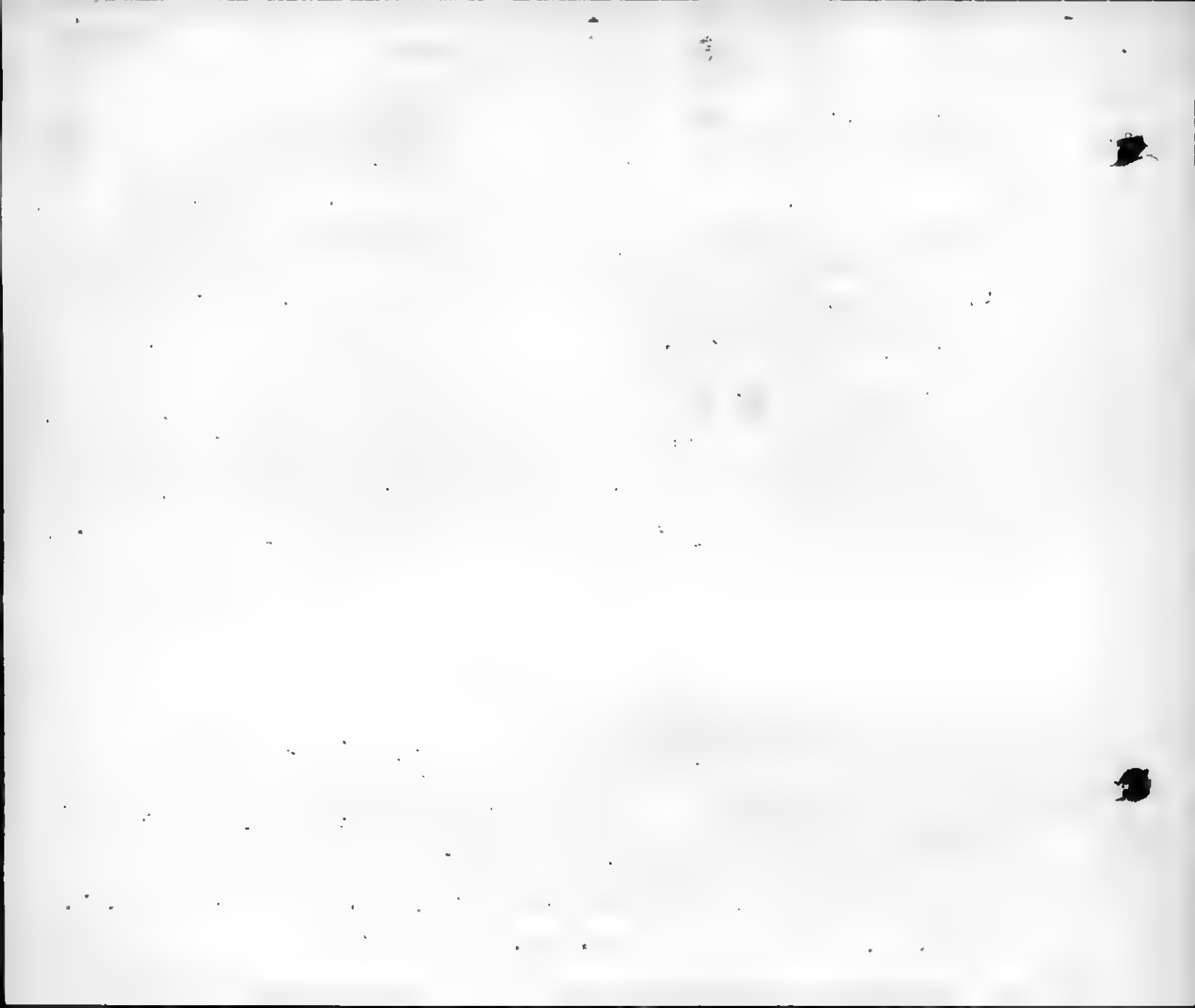
5818 CERTIFICATE OF DEATH

05804

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>1 HOUR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. STREET ADDRESS <u>2517 PLYERS MILL ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>MOTT</u> Last <u>MORSE</u>		4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-1885</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u>	11. IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANUFACTURER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MANUFACTURING</u>	
11. BIRTHPLACE (State or foreign country) <u>PENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>NATHANIAL MORSE</u>		14. MOTHER'S MAIDEN NAME <u>CLYNTHIA SHARP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. MARTHA ELLEN KOPELKY</u>		Address <u>10411 HUTTINGER PL. S.E. MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Heart Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1958</u> to <u>April 30, 1959</u> , that I last saw the deceased alive on <u>May 1, 1959</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sharpe</u>		ADDRESS (Street, city or town, state) <u>10511 Summit Ave</u> DATE SIGNED <u>5-1-59</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe M.D.</u>		<u>Kensington, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>5-3-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Onondaga Valley Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Onondaga County, N. Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	
DATE <u>MAY 4 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





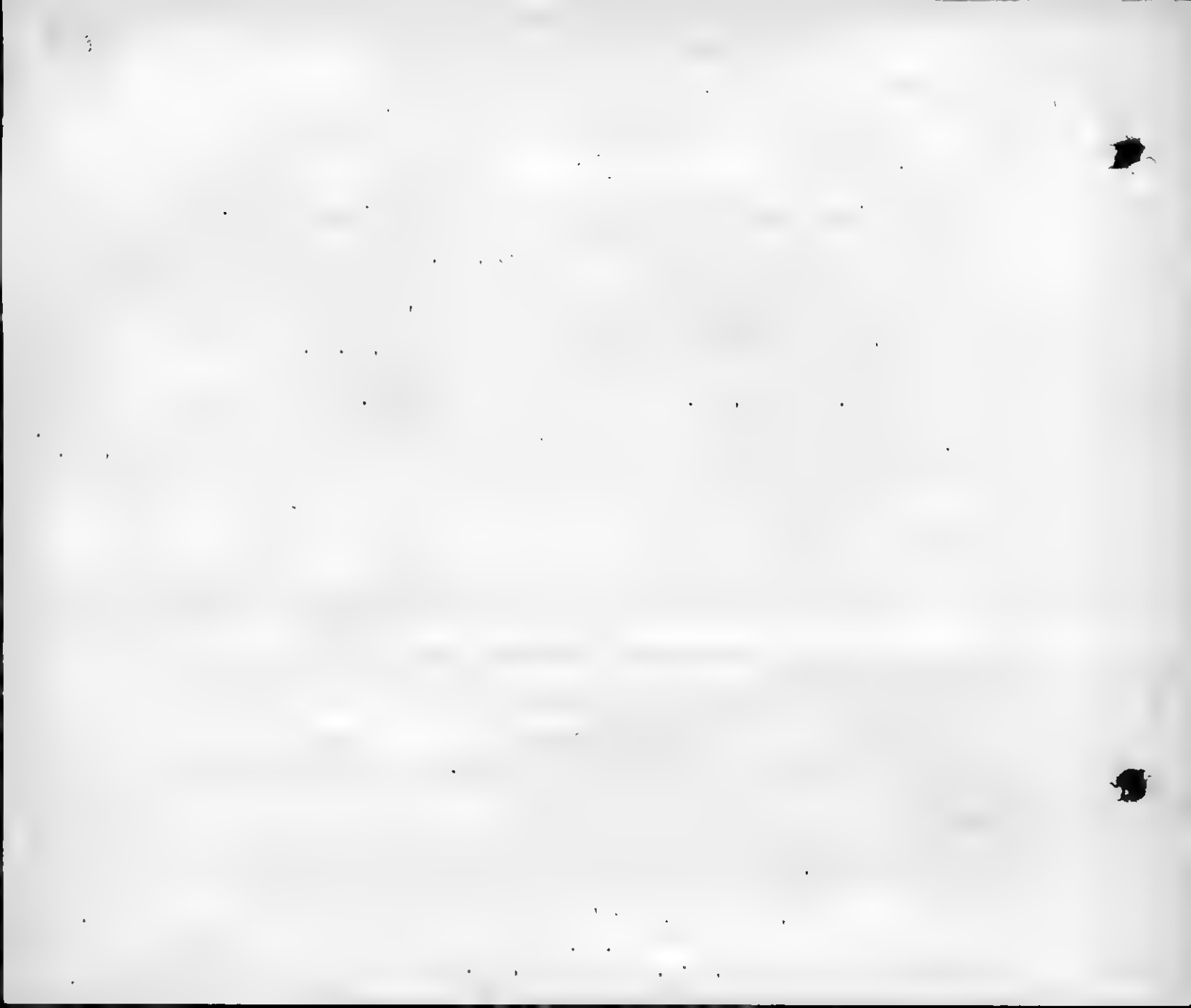
## 5820 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Havarest Nursing Home 571 University Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>David Boyd Murdock, Jr.</b>		4. DATE OF DEATH Month Day Year <b>May 17 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 16, 1885</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pressman (R)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>David B. Murdock, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Annie E. Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>577 07 6841A</b>	
17. INFORMANT <b>Grace C Long</b>		Address <b>216 Williamsburg Rd. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3-4 yrs</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 19, 59</b> , to <b>May 17, 59</b> , that I last saw the deceased alive on <b>5/15/59</b> , 19 <b>59</b> , and that death occurred at <b>6:44 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Aud</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>906 Colsonville Rd 5/17/59</b>	
PHYSICIAN'S NAME (Type) <b>William D. Aud</b>		<b>Silver Spring, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 20, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Catholic</b>	22d. LOCATION (City, town, or county) (State) <b>Alexandria Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Beverly Mountcastle</b>		ADDRESS <b>P. O. Box 65</b>	24a. REC'D BY REGISTRAR <b>MAY 18 '59</b>
<b>Cunningham Funeral Home, Inc. Alexandria, Va.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5821

## CERTIFICATE OF DEATH

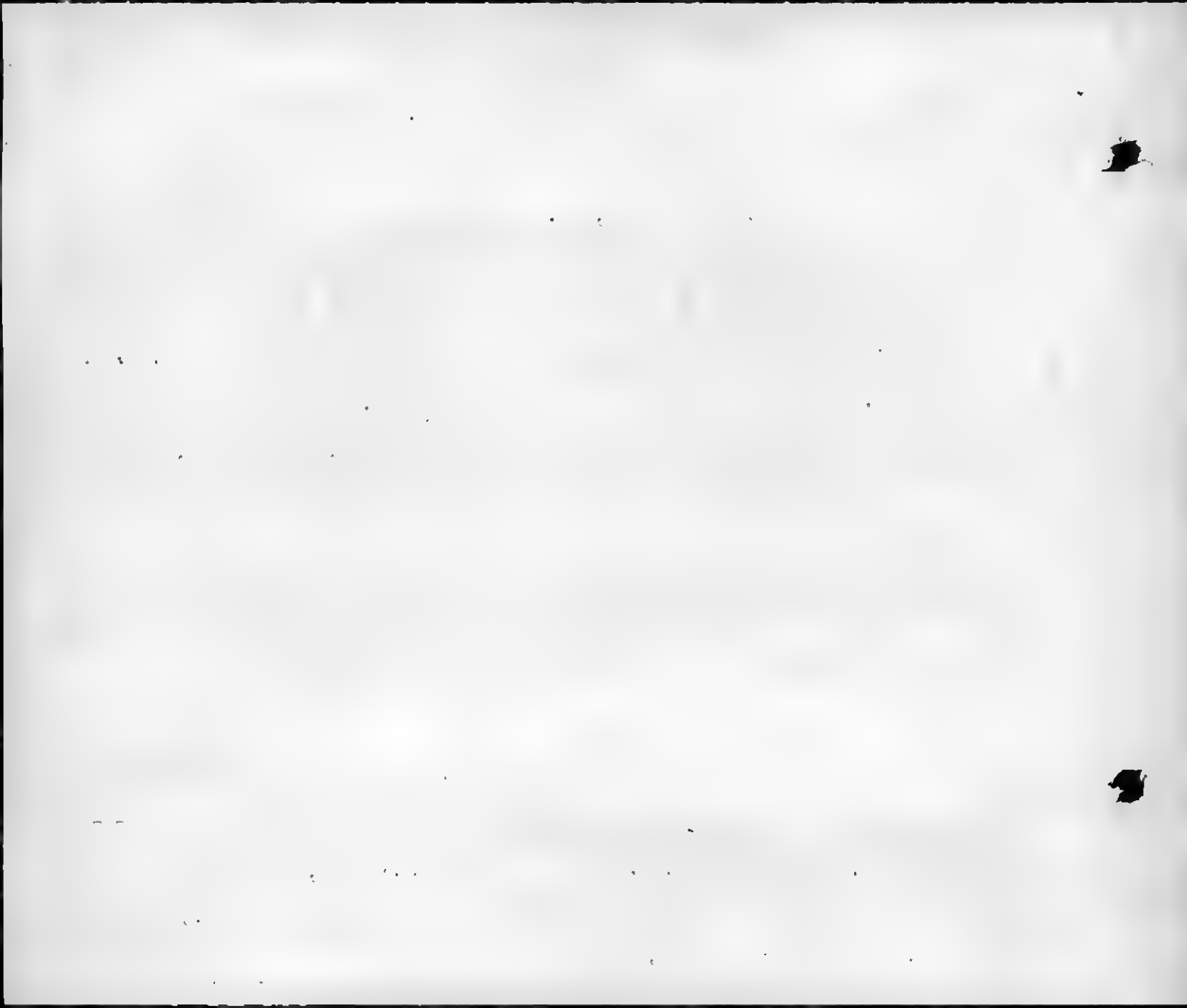
05806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Norfolk</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u>	
c. LENGTH OF STAY IN b. <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lamar</u> Middle <u>Law</u> Last <u>Murphy</u>		4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 20, 1901</u>
9. AGE (In years last birthday) <u>57</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William J. Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Bohle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO <u>Not available</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the Rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 24</u> , 19 <u>59</u> , to <u>May 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>59</u> , and that death occurred at <u>8:35 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Richard Lee</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>5-5-59</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>G. Richard Lee, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/9/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Princess Ann Co., Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24. REC'D BY REGISTRAR DATE <u>MAY 8 1959</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Haines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5822

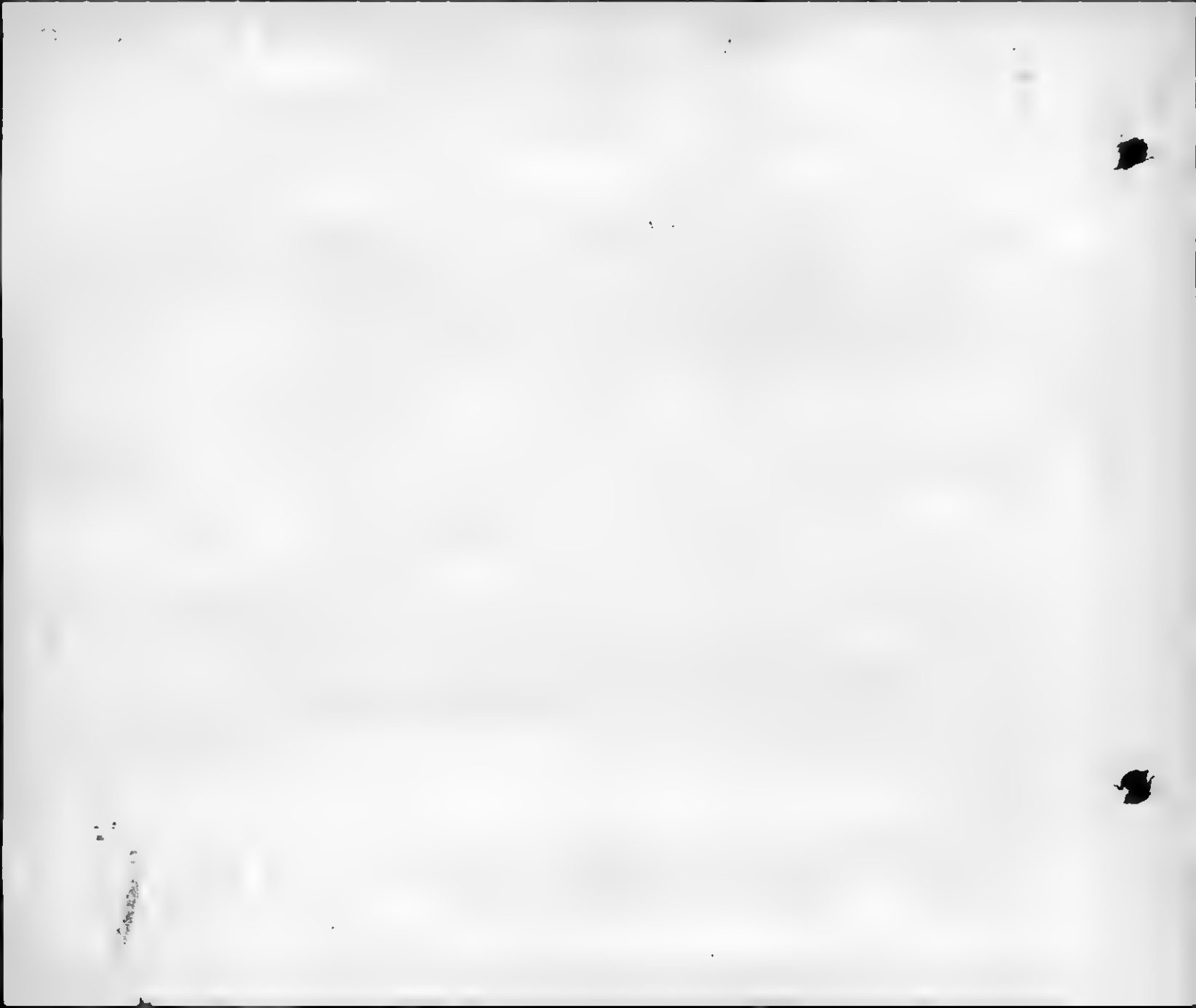
06979

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Burrington Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jane</u> Middle <u>E</u> Last <u>Neasey</u>		4. DATE OF DEATH Month <u>5</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>89</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Jane Neasey</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Neasey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>William Neasey</u> Address <u>206 Purnore St</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>60000</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bilateral Pyelitis</u> DUE TO (c) <u>None</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/2/59</u> to <u>5/29/59</u> , that I last saw the deceased alive on <u>5/27/59</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>5/29/59</u>	
PHYSICIAN'S NAME (Type)		M.D. <u>[Signature]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-2-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>3831 9th Ave NW</u>		24a. REC'D BY REGISTRAR <u>JUN 1 0 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5823

## CERTIFICATE OF DEATH

05807

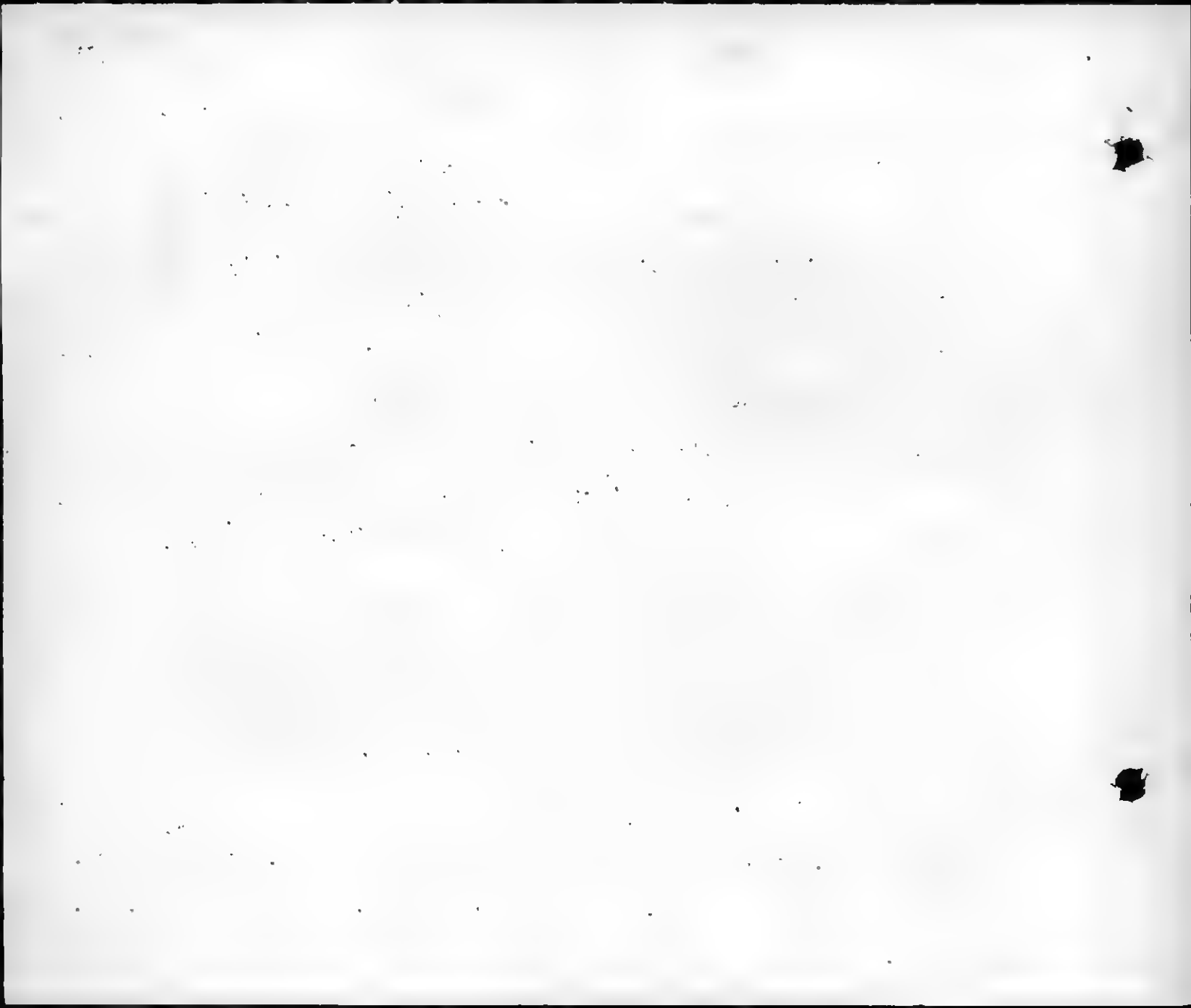
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Charles</u> Last <u>Nicholson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/96</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Broker</u>	
11. BIRTHPLACE (State or foreign country) <u>Dickerson Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Claude Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>579-03-2769</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CANCER (SMALL-CELL) OF LEFT LUNG</u> 112X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTATIC CANCER TO CERVICAL VERTEBRA</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 MO.</u> <u>8 MO.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> to <u>MAY 3, 1957</u> , that I last saw the deceased alive on <u>MAY 2, 1957</u> , and that death occurred at <u>1:20 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo M. Curtis</u>		ADDRESS (Street, city or town, state) <u>8218 WISCONSIN AVE., BETHESDA, MD.</u> DATE SIGNED <u>5/3/57</u>	
PHYSICIAN'S NAME (Type) <u>Leo M. Curtis</u>		<u>8218 Wisconsin Ave. Bethesda, Md.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 5 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5824

## CERTIFICATE OF DEATH

05808

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Montgomery</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney, Maryland</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b> d STREET ADDRESS <b>Trotter Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Janet Eileen Niemann</b>		4. DATE OF DEATH Month Day Year <b>May 30 1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1959</b>		9. AGE (In years last birthday) yrs <b>2</b> Months <b>14</b> Days <b>26</b> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>New Born</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13. FATHER'S NAME <b>William Robert Niemann</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Margaret Dorothy</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Montgomery County General Hospital, Inc.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis, bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>5-28-</b> <b>1959</b> , to <b>5-30-</b> <b>1959</b> , that I last saw the deceased alive on <b>5-30-</b> <b>1959</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>Charles S. Whitaker</b> M.D.		PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D.</b> <b>Clarksville, Maryland</b> <b>5-31-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>5-2-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Louis</b>	
22d. LOCATION (City, town, or county) <b>Clarksville, Md</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>JUN 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hearn</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



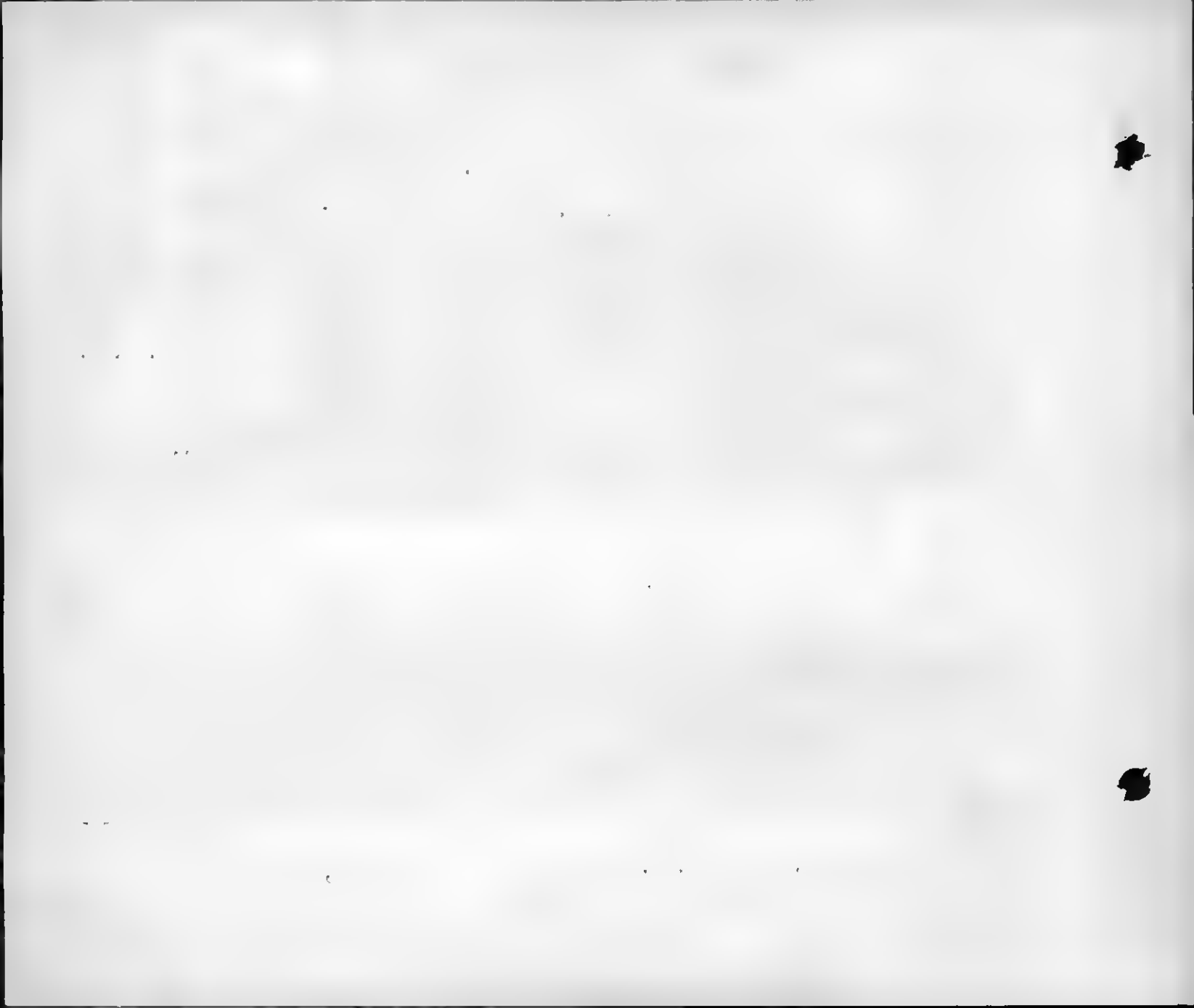
05809

Reg. Dist. No.

5825

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>86 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> <b>1612</b>	
f. STREET ADDRESS <b>3711 Eastern Avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Evelyn</b> Middle <b>Minnie</b> Last <b>Noblette</b>		4. DATE OF DEATH Month <b>May</b> Day <b>6,</b> Year <b>1959</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 3, 1903</b>	
9. AGE (In years last birthday) <b>55</b> yrs		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b> Hours <b>55</b> Min <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unascertainable</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward McAbee</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Morgan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>248-09-4926</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Vascular Collapse</b> DUE TO <b>Lymphosarcoma</b> DUE TO <b>? Pseudomonas Septicemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>6 years</b> <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0.1</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 9, 1959</b> , to <b>May 6, 1959</b> , that I last saw the deceased alive on <b>May 6, 1959</b> , and that death occurred at <b>7:55 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b> DATE SIGNED <b>5-7-59</b>			
ACTUAL SIGNATURE <b>Edgar H. Levin</b> M. D.		DATE SIGNED <b>5-7-59</b>	
PHYSICIAN'S NAME (Type) <b>Edgar H. Levin, M. D.</b>		DATE SIGNED <b>5-7-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-9-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) <b>COLMAR MANOR, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home Inc.</b> ADDRESS <b>mt. Rainier, Maryland</b>		24a. REC'D BY REGISTRAR <b>May 11 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		DATE <b>May 11 '59</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4



## CERTIFICATE OF DEATH

05810

Reg. Dist. No.

5728

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>106 Charles Street</b>		/d. STREET ADDRESS <b>106 Charlest Street</b>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>LENOX</b> Last <b>ORRISON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>1959</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/4/79</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR: Months <b>6</b> Days <b>2</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Montg. County</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Kate B. Wren</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-18-1837</b>	
17. INFORMANT <b>George L. Orrison-son-same as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL EMBOLIZATION</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HEPATIC COMA</b> DUE TO (c) <b>BRONCHIOGENIC CARCINOMA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>TEN HOURS</b> <b>TWO DAYS</b> <b>8 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTHRIOCLEROTIC HEART DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB. 12</b> , 1959, to <b>MAY 6</b> , 1959, that I last saw the deceased alive on <b>MAY 5</b> , 1959, and that death occurred at <b>4 A. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>26 N. SUMMIT AVE. GARY 1959</b> DATE SIGNED ACTUAL SIGNATURE <b>Gordon S. Rosenberger M.D.</b> PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger</b> <b>PRITHWERSBURG, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/8/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>MAY 8 1959</b>	
ADDRESS <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5826

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05811

Reg. Dist. No.

1  
FOR STATE  
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville</u>	c. LENGTH OF STAY IN 1b <u>15 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Barnesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		f. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha Helen Painter</u>		4. DATE OF DEATH Month Day Year <u>May 29 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-19-1892</u>
9. AGE (In years last birthday) <u>66 yrs</u>		10. IF UNDER 1 YEAR Months Days <u>66</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Hildebrand</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Elmer Painter (husband)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brusca</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BRUSCA</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) (State) <u>Barnesville md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton, Barnesville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be filed within 24 hours after death. If any delay is necessary, please advise the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

5827

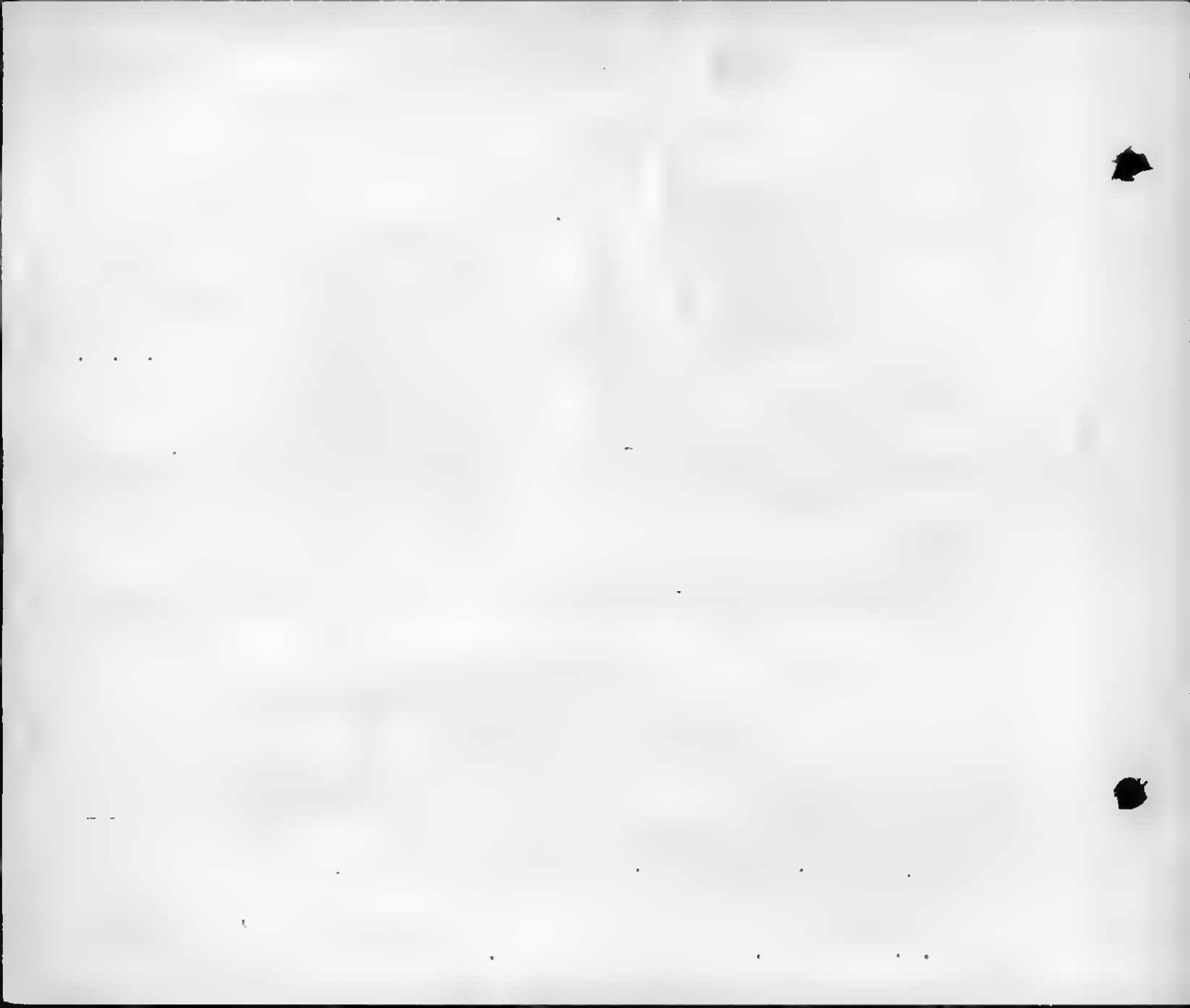
Reg. Dist. No.

05812

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saint Benedict</u> <u>7</u>	
c. LENGTH OF STAY IN TB <u>2 days</u>		d. STREET ADDRESS <u>Box 186</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>(none)</u> Last <u>Pawliske</u>		4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 29, 1916</u> <u>42</u> yrs.
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Mandrick</u>		14. MOTHER'S MAIDEN NAME <u>Anna Kutsick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>206-01-4621</u>	
17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma, Advanced</u> <u>1771X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pyelonephritis, Chronic</u> DUE TO (c) <u>Carcinoma of Cervix</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u> <u>8 Months</u> <u>14 Months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 4</u> , 19 <u>59</u> , to <u>May 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 6</u> , 19 <u>59</u> , and that death occurred at <u>2:40 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S. Dillon</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>John S. Dillon, M. D.</u>		DATE SIGNED <u>5-7-59</u>	
22a. BURIAL, CREMATION, REMOVAL <u>Removal</u>	22b. DATE THEREOF <u>5/8/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>--</u>	22d. LOCATION (City, town, or county) (State) <u>Carrolltown, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.-2901 14th St. N.W.</u> <u>Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5828

CERTIFICATE OF DEATH

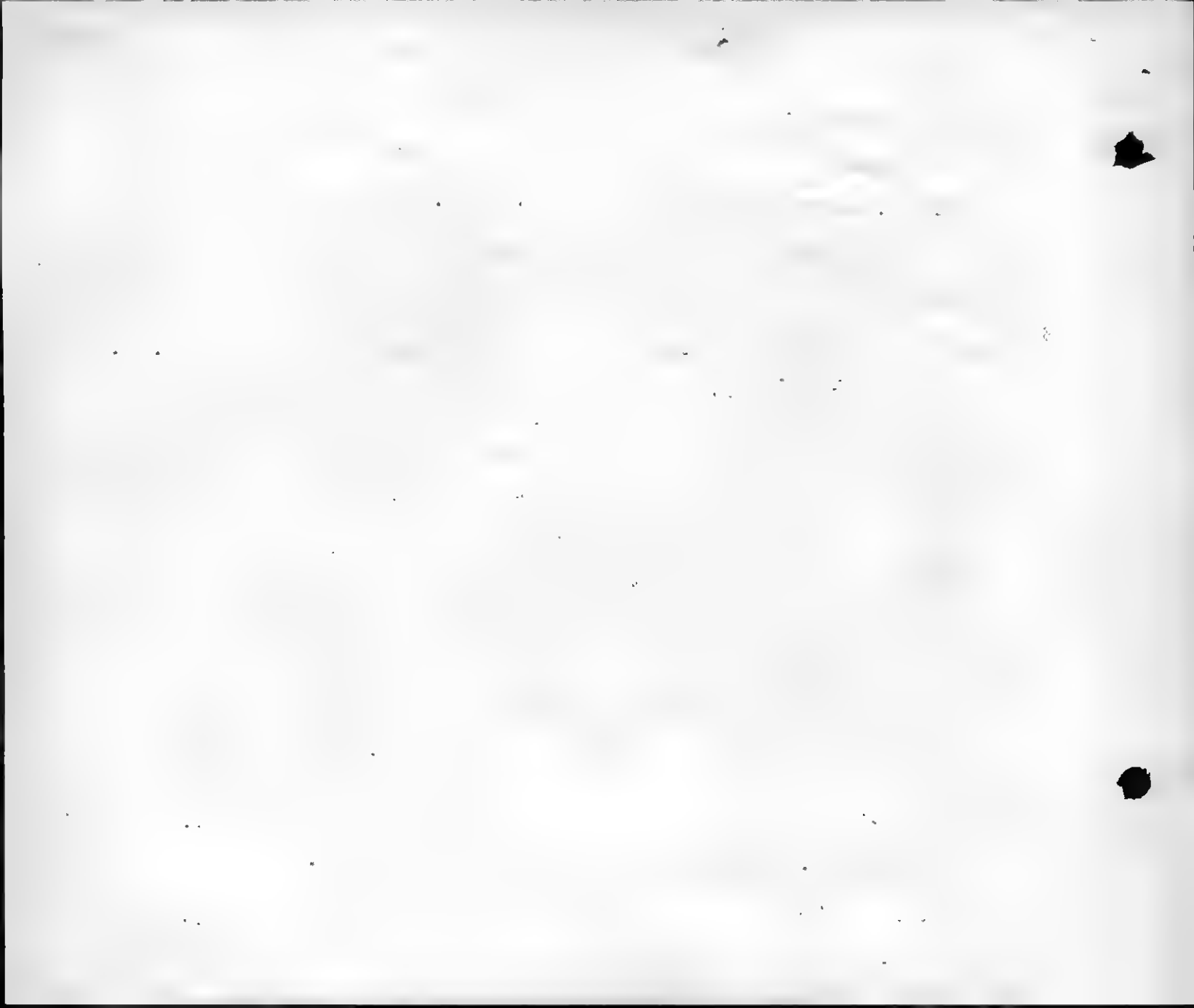
05813

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4612 N. Chelsea Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JUDITH</b> Middle <b>MARY</b> Last <b>PERRELL</b>		4. DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>1959</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/18/57</b>
9. AGE (In years last birthday) <b>2</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>4</b> Hours <b></b> Min <b></b>	11. IF UNDER 24 HRS Months <b></b> Days <b></b> Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Upton J. Jack Perrell, Jr</b>		14. MOTHER'S MAIDEN NAME <b>Margaret J Sartwell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Jack Perrell (father)</b>		Address <b>Same as Item # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5 Acute angiotensin shock</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>Cerebral shock</b> (c) <b>myocardial infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 MIN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 1958</b> to <b>May 1959</b> , that I last saw the deceased alive on <b>May 20</b> , 19 <b>59</b> , and that death occurred at <b>8:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <b>Leo I. Donovan</b> M.D. <b>8016 Old Georgetown Rd. Bethesda, Md.</b> DATE SIGNED <b>5/23/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/25/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>
22d. LOCATION (City, town, or county) <b>Rockville, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 27 '59</b>	
ADDRESS <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5829

## CERTIFICATE OF DEATH

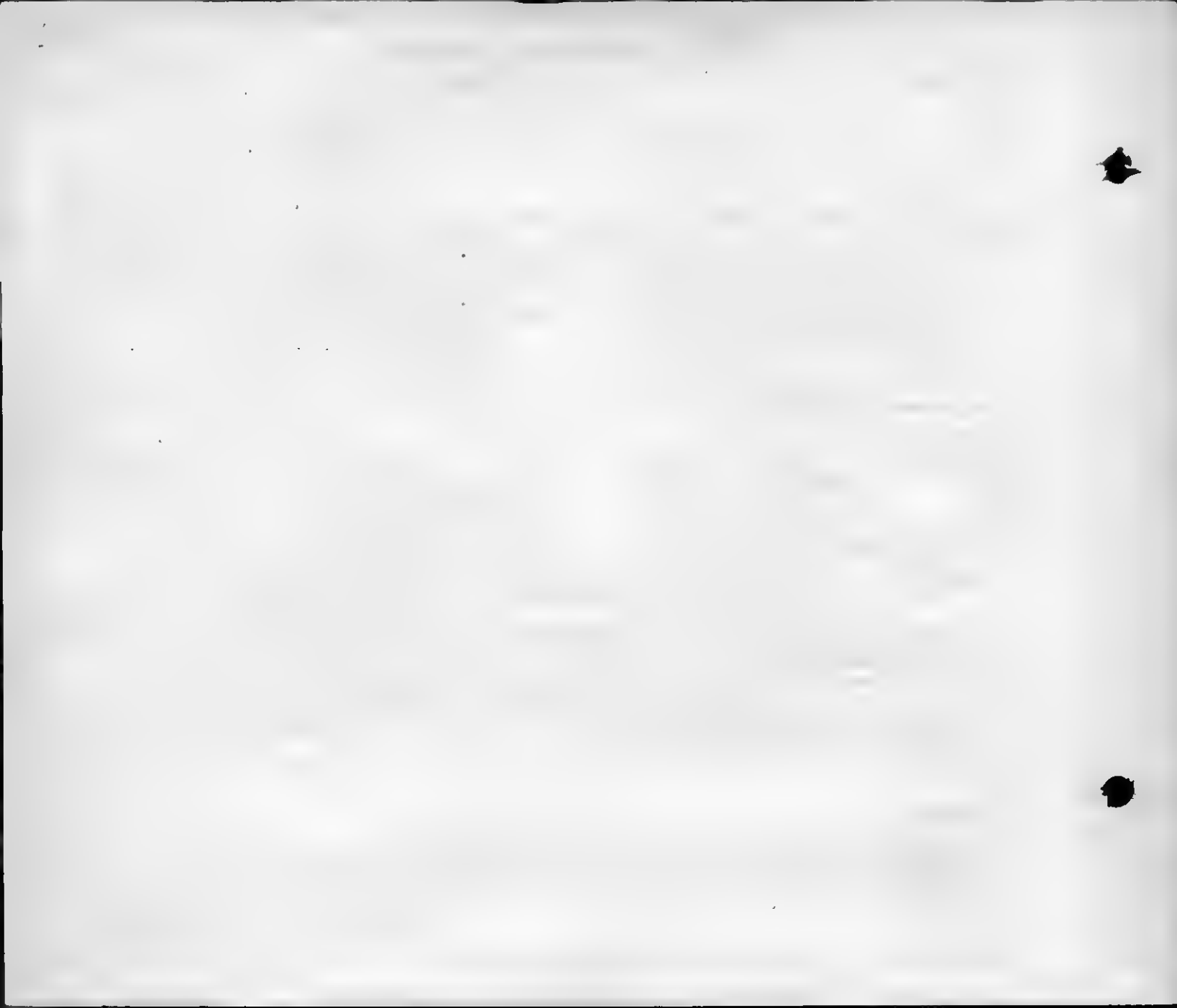
05814

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Residence</b>		d. STREET ADDRESS <b>15006 - Dalton Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>LOTTIE</b> Middle <b>LOUISE</b> Last <b>PERRY.</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 11, 1892</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James S Perry</b>		14. MOTHER'S MAIDEN NAME <b>Ada E Ward</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Ralph Perry</b>		Address <b>same as above.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> (c) <b>with hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1.5 months</b> <b>9 years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 17, 1959</b> , to <b>5-15-1959</b> , that I last saw the deceased alive on <b>5-15-1959</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C P Ryland</b>		ADDRESS (Street, city or town, state) <b>4400 - 49 St NW</b>	
PHYSICIAN'S NAME (Type) <b>C P RYLAND</b>		DATE SIGNED <b>5-16-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>May 17, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lees Crematorium</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington D.C.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>MAY 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05815

## 5830 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Hillside</u> COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ednor</u>				c. LENGTH OF STAY IN 1b <u>8 mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belmont Nursing Home</u>				e. STREET ADDRESS <u>5203 West Hillside Dr</u>			
3. NAME OF DECEASED (Type or print) <u>Robert F. PERRY</u>				4. DATE OF DEATH <u>5</u> Month <u>2</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown about 54</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Sarah Williams, P.G. Hosp P.G. Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage -</u> DUE TO <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Arterio Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Oct 13</u> , 19 <u>59</u> , to <u>5/21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/30</u> , 19 <u>59</u> , and that death occurred at <u>4:00</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J.M. Bird</u>				ADDRESS (Street, city or town, state) <u>Sandy Hb Md</u>			
PHYSICIAN'S NAME (Type) <u>J.M. Bird</u>				DATE SIGNED <u>5/2/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 5 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W Barber</u>				ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 6 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

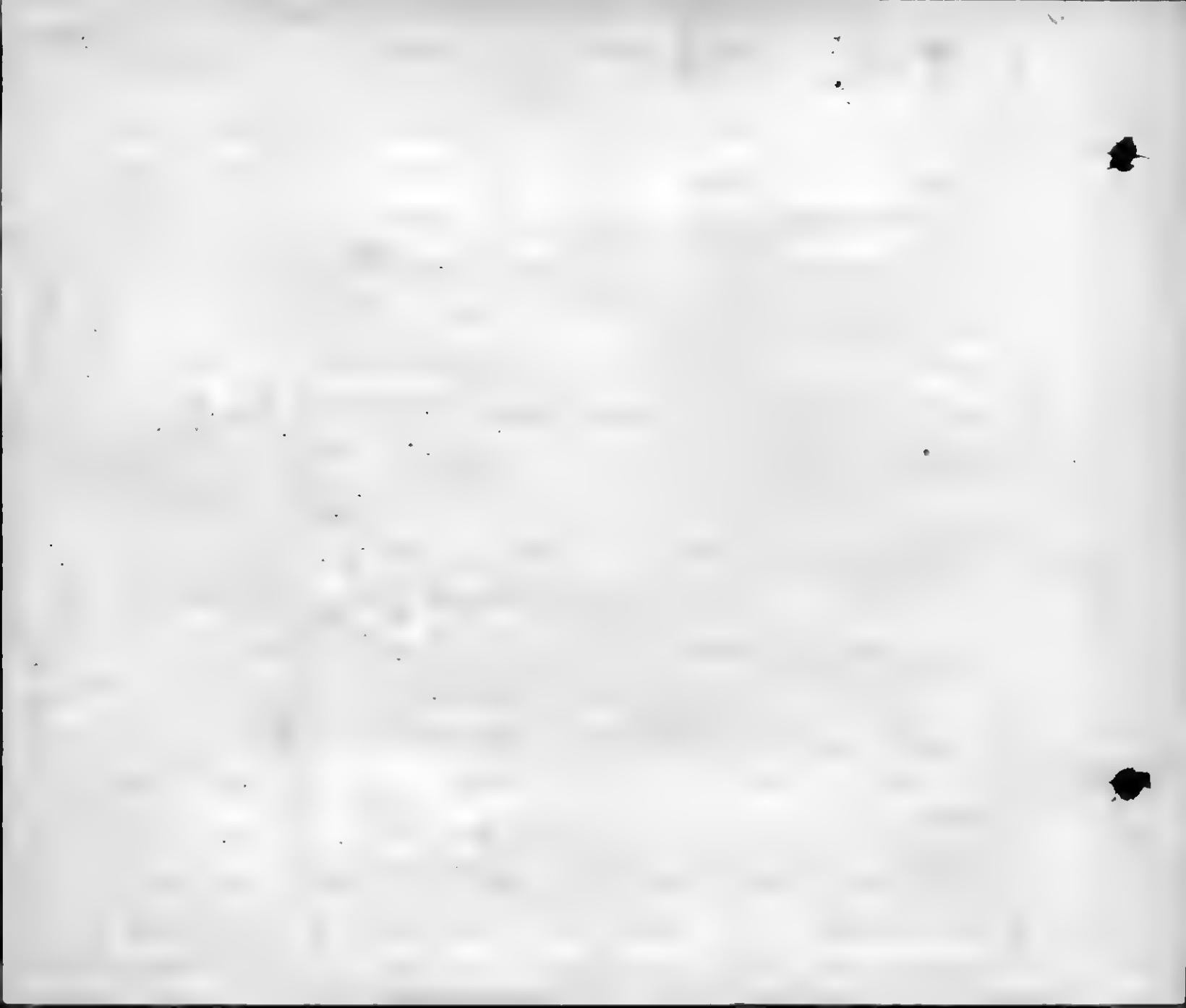
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5718 CERTIFICATE OF DEATH

05816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>21 COLUMBIA AVE.</u>				d. STREET ADDRESS <u>21 Columbia Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMIL</u> <u>WILLIAM</u>				4. DATE OF DEATH Month Day Year <u>MAY</u> <u>28</u> <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>L</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1886</u>	9. AGE (In years last birthday) yrs. <u>72</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>Denmark</u>	
11. FATHER'S NAME <u>CHRIS PETERSEN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>MRS. E. V. PETERSEN (same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INANITION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (c) <u>CHRONIC MYOCARDIAL INFARCTION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 1, 1958</u> , to <u>MAY 28, 1959</u> , that I last saw the deceased alive on <u>MAY 28, 1959</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>800 Pershing Drive, S.E. Md</u> <u>5/28/59</u>			
PHYSICIAN'S NAME (Type) <u>DR. WILLIAM L. DELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 29, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fair Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>257 Carroll Park Dr. S.E.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

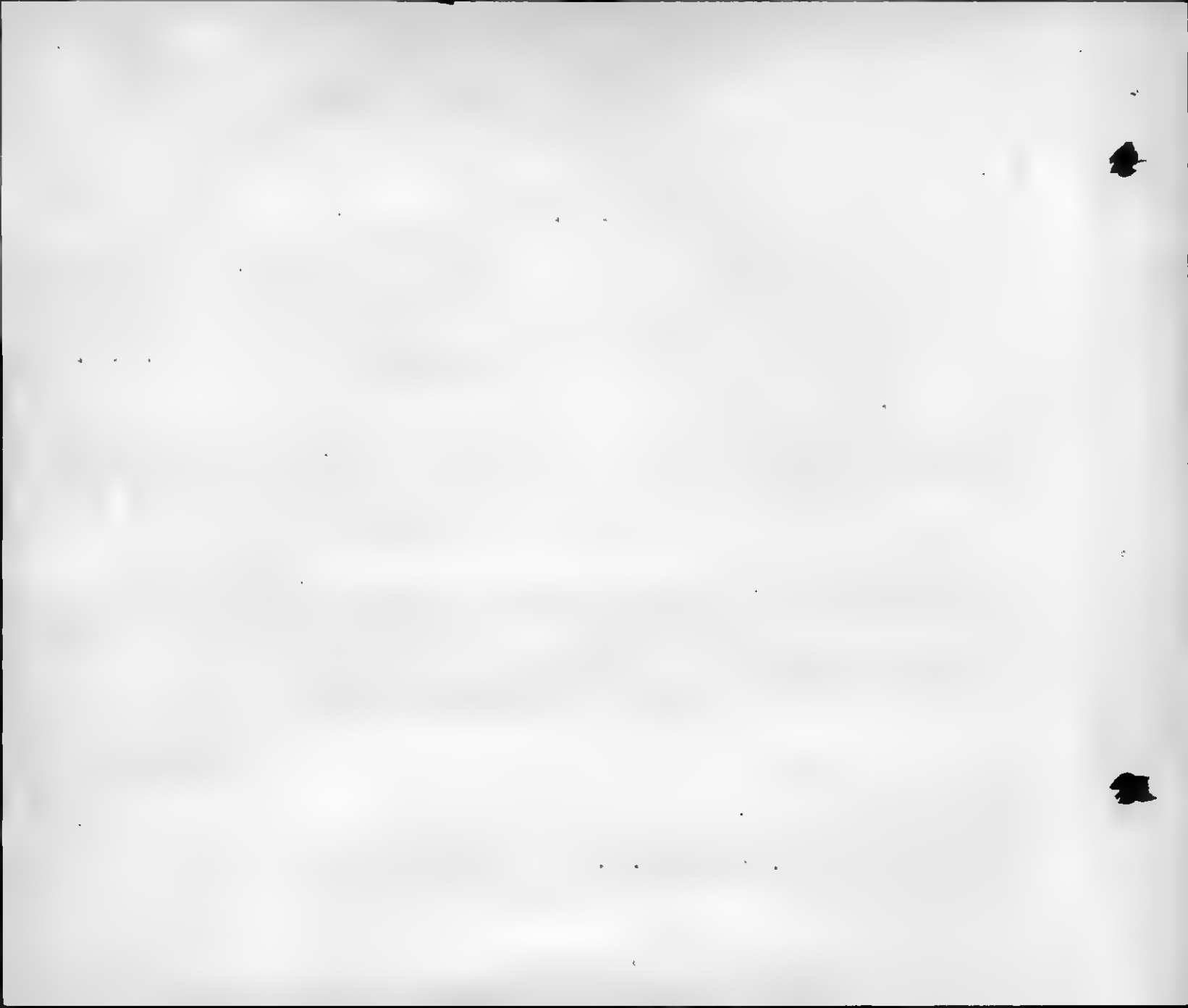
## 5831 CERTIFICATE OF DEATH

05817

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>7 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Janice Emily Pfaff</b>			4. DATE OF DEATH Month Day Year <b>May 16, 1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 27, 1927</b>		9. AGE (In years last birthday) <b>31</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>			
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>			13. FATHER'S NAME <b>Robert L. Strickland</b>				
14. MOTHER'S MAIDEN NAME <b>Ellen Carlson</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO. <b>Unavailable</b>			17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b> DUE TO (b) <b>Metastatic Carcinoma of Breast to</b> DUE TO (c) <b>lymphatic, hepatic, lung systems.</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>17X</b> <b>5 mos.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>May 16, 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>May 9, 1959, to May 16, 1959</b>			
20f. (City or town) <b>Bethesda</b>		20g. (County) <b>Montgomery</b>		20h. (State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>May 9, 1959</b> , to <b>May 16, 1959</b> , that I last saw the deceased alive on <b>May 16, 1959</b> , and that death occurred at <b>10:27 P.M.</b> , from the causes and on the date stated above							
ACTUAL SIGNATURE <b>Donald A. Kellogg</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b>		DATE SIGNED <b>5-17-59</b>			
PHYSICIAN'S NAME (Type) <b>Donald A. Kellogg, M.D.</b>		NATIONAL INSTITUTES OF HEALTH <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>5/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rochester, New York</b>			
22d. LOCATION (City, town, or county) <b>Rochester, New York</b>		22e. (State) <b>New York</b>		22f. (Country) <b>U. S. A.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 19 59</b>			
24b. REGISTRAR'S SIGNATURE <b>Charles L. Kneass</b>		24c. (City, town, or county) <b>Bethesda, Maryland</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**5719 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

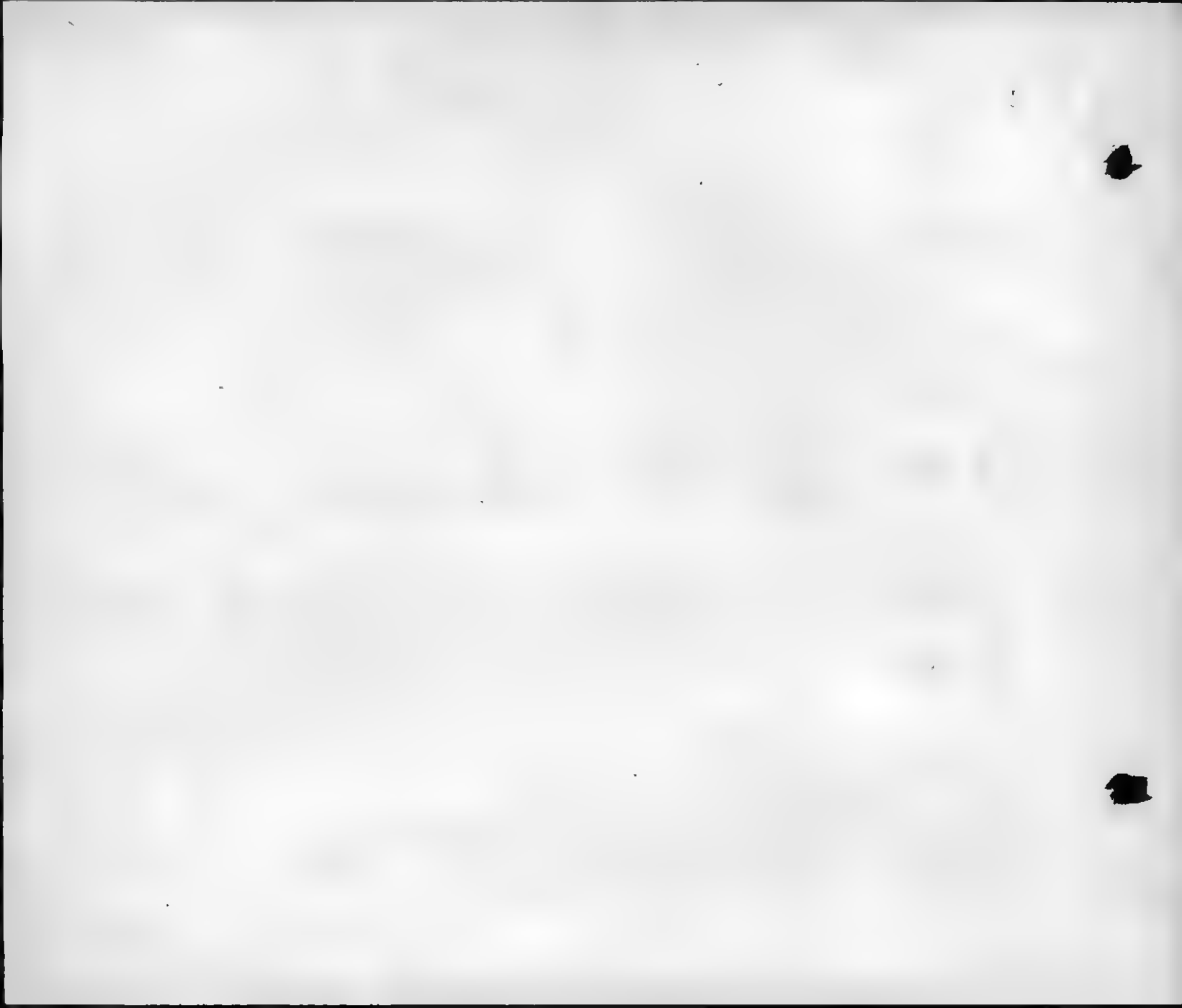
**05818**

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDIC./ EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the cert. by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If inst tut on Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>35 min.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>			d. STREET ADDRESS <u>8202 New Hampshire Ave.</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Phillip</u> First <u>(NMN)</u> Middle <u>Phillips</u> Last			4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-14</u>		9. AGE (In years last birthday) <u>44</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Turkey</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Anthony Phillips</u>			14. MOTHER'S MAIDEN NAME <u>Frances Vitali</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion c myocardial infarction 1 hr.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>8 May 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		ADDRESS <u>254 Carroll Rd NE 4.C.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

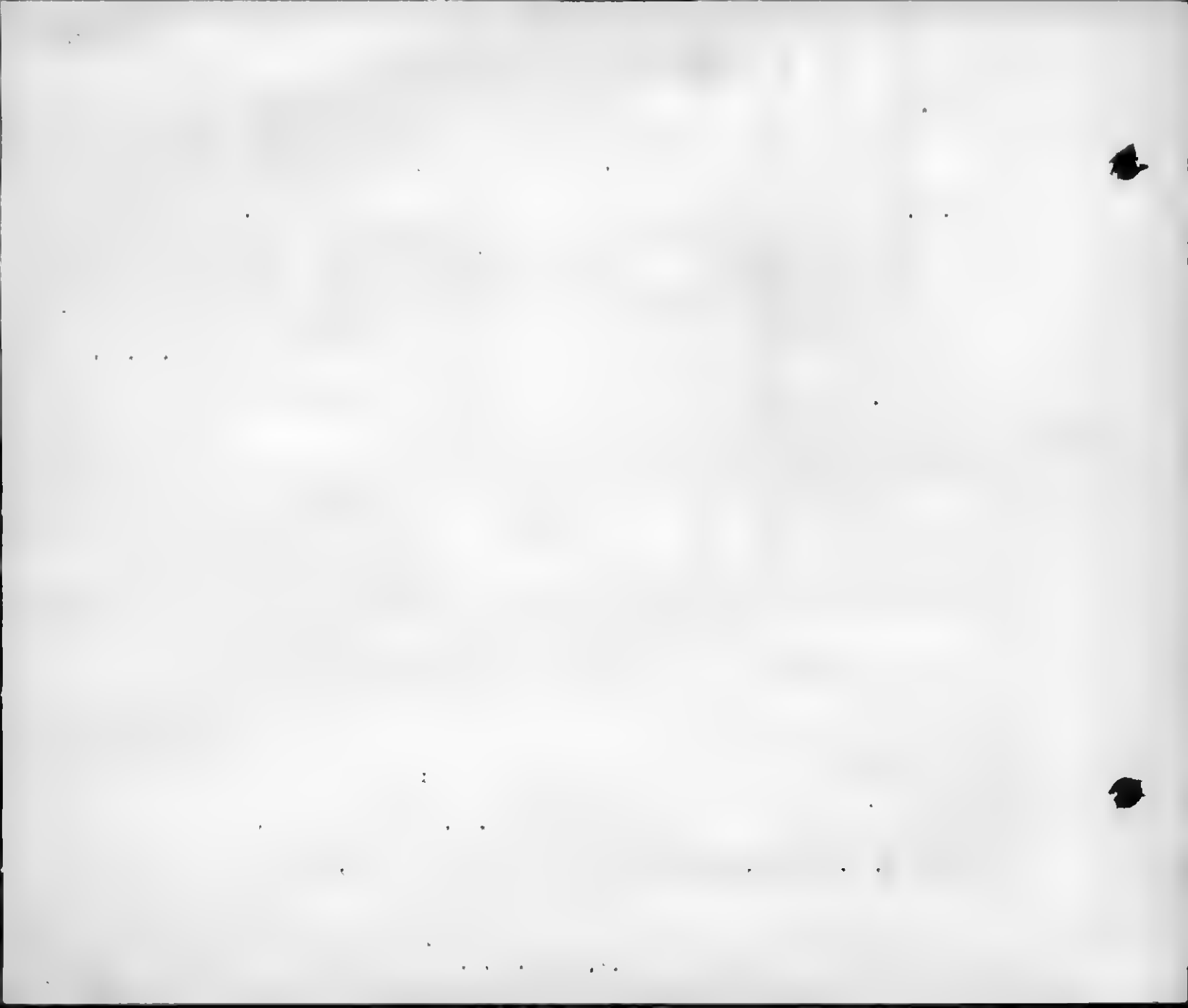


## 5832 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>9 hrs. 16 min</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Pierce</b>		4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21 May 1959</b>
9. AGE (In years last birthday) yrs. <b>9</b>		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>16</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert L. Peirce</b>		14. MOTHER'S MAIDEN NAME <b>Rose Casterline</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity (2 lbs.)</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 21</b> , 19 <b>59</b> , to <b>May 21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 21</b> , 19 <b>59</b> , and that death occurred at <b>11:53 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. L. Walton</b>		ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NMMC</b> DATE SIGNED <b>5-21-59</b>	
PHYSICIAN'S NAME (Type) <b>H. L. WALTON, LT MC USN</b>		<b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-25-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Huntemann &amp; Son Funeral Home</b>		ADDRESS <b>5732 Georgia Ave. N.W. Wash. D.C.</b> REC'D BY REGISTRAR DATE <b>MAY 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>			

TO INDIVIDUAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





5833

## CERTIFICATE OF DEATH

Reg. Dist. No.

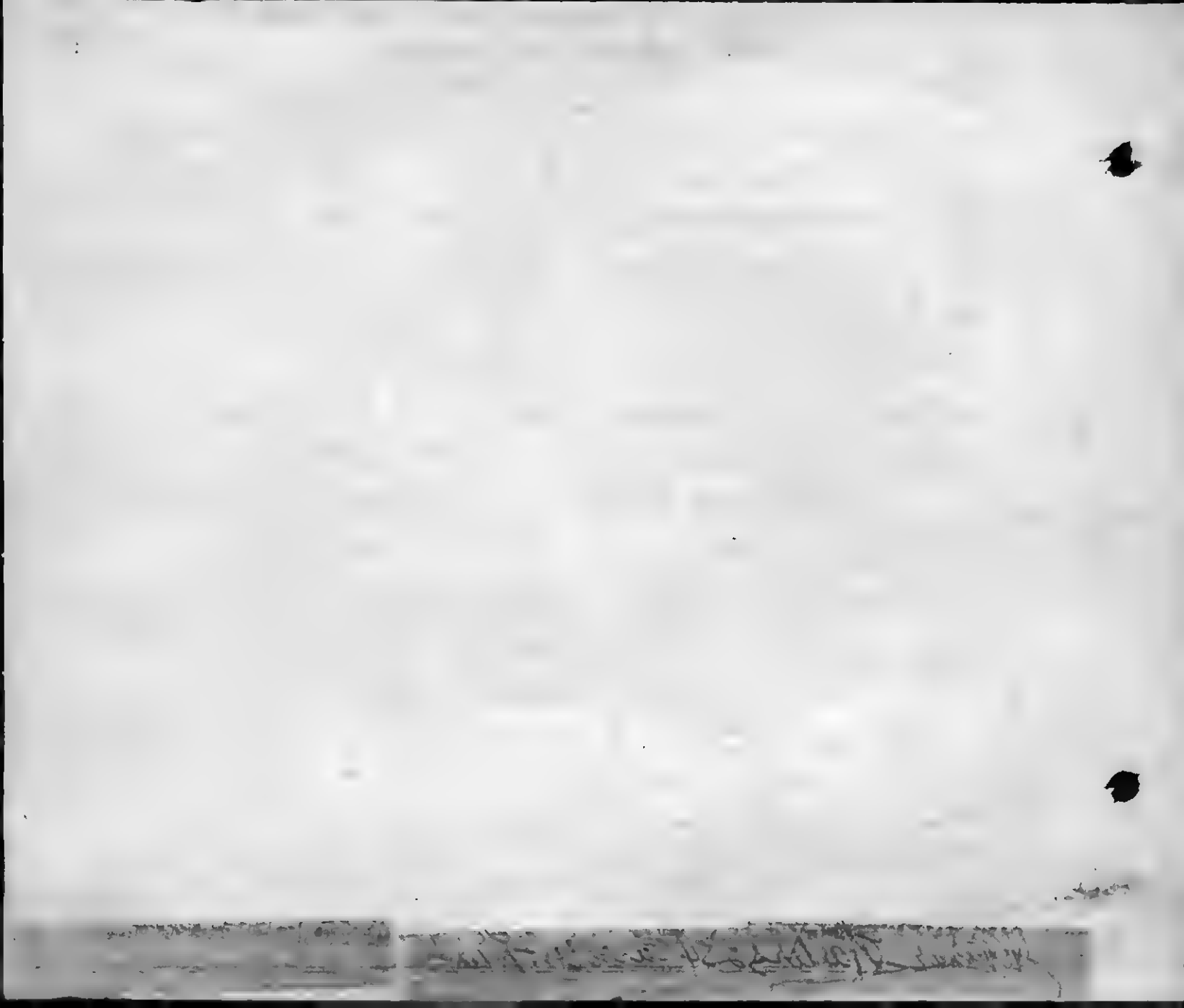
05820

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8910 Bradford Rd.</u>		e. STREET ADDRESS <u>8910 Bradford Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Clara</u> Last <u>Piper</u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 18 1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Buena Vista Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elitah Lee</u>		14. MOTHER'S MAIDEN NAME <u>Susan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Della Twigg</u>		Address <u>8910 Bradford Rd. Silver Spring Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Old Age</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>February, 1959</u> , to <u>May 21, 1959</u> that I last saw the deceased alive on <u>May 12, 1959</u> , and that death occurred at <u>11 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10110 Georgia Ave. Silver Spring Md.</u> DATE SIGNED <u>5/21/59</u> ACTUAL SIGNATURE <u>Edward J. Richards</u> PHYSICIAN'S NAME (Type) <u>EDWARD J. RICHARDS</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GREENHILL CEMETERY</u>
22d. LOCATION (City, town, or county) (State) <u>BUENA VISTA VA.</u>		22e. REC'D BY REGISTRAR <u>DATE</u>
22f. FUNERAL DIRECTOR'S SIGNATURE <u>254 Carroll St. N.E.</u>		22g. REGISTRAR'S SIGNATURE <u>DATE</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5834

CERTIFICATE OF DEATH

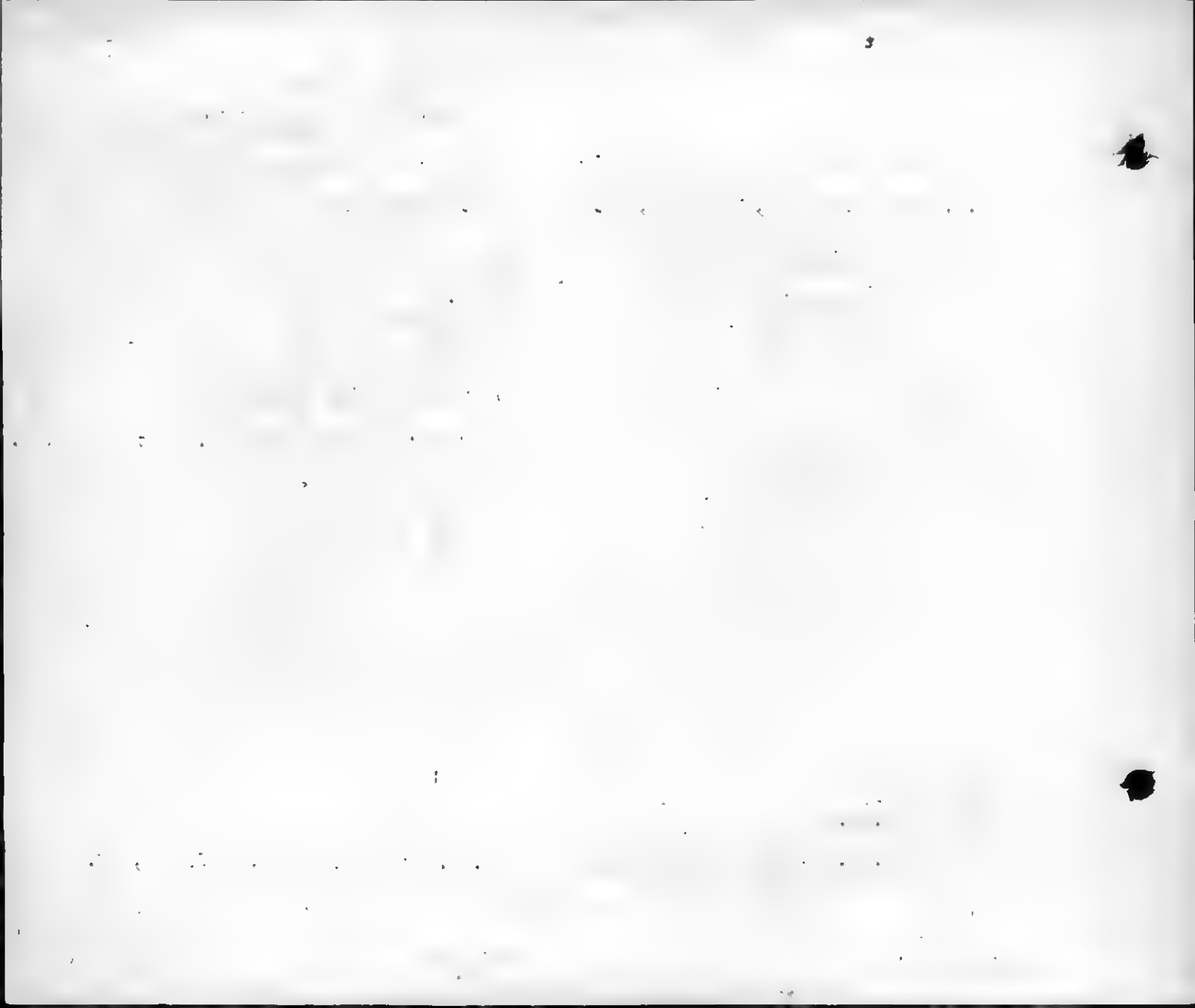
05821

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>	c. LENGTH OF STAY IN 1b <b>2 Months</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>2116 Chapman Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Barry</b> Last <b>POOLE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-15-54</b>
9. AGE (In years last birthday) <b>4</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Canada</b>
12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>		13. FATHER'S NAME <b>William POOLE</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Christina MAC DONALD</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>William POOLE 2116 Chapman Dr. Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>aplastic anemia secondary to total body radiation in R for terminal lymphatic leukemia.</b> DUE TO (b) <b>body radiation in R for terminal</b> DUE TO (c) <b>lymphatic leukemia.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>23 March</b> 19 <b>59</b> to <b>24 May</b> 19 <b>59</b> , that I last saw the deceased alive on <b>24 May</b> 19 <b>59</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>H. L. Walton</b> M.D.		PHYSICIAN'S NAME (Type) <b>H. L. WALTON LT MC USN U. S. NAVAL HOSPITAL, BETHESDA, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5-29-59 (Approx)</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Heatherside</b>	22d. LOCATION (City, town, or county) (State) <b>New Glasgow Nova Scotia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R A Pumphrey</b>		24a. REC'D BY REGISTRAR <b>MAY 26 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5720

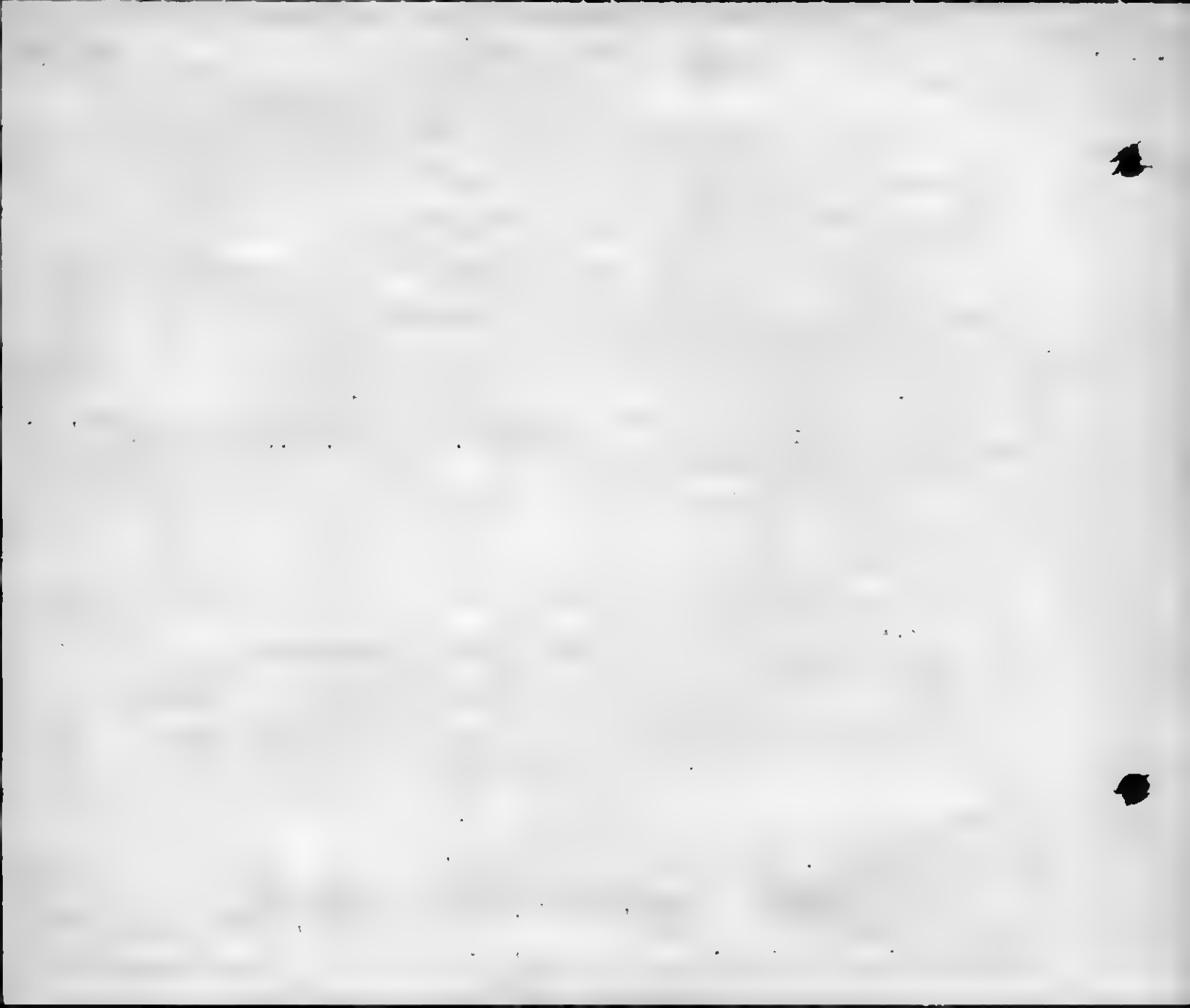
## CERTIFICATE OF DEATH

Reg. Dist. No.

05822

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>6 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7402 Garland Ave.</u>				e. STREET ADDRESS <u>17402 Garland Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Lynton</u> Middle <u>Pritchard</u> Last				4. DATE OF DEATH <u>May 9</u> 19 <u>59</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 18 1901</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Relations</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Relations</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT W. PRITCHARD</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE B. ALMOND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>577-07-284</u>		17. INFORMANT <u>ROBERT L. PRITCHARD, JR., 202 A SOUTH LEE STREET</u> Address <u>FALLS CHURCH, VA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Myocardial Infarction 1958</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>May 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 7</u> , 19 <u>59</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. Whitlock</u>		M.D. <u>7701 Carroll Ave</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>5-9-59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>		<u>Takoma Park Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEAHN'S CHAPEL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>LURAY VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>MAY 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



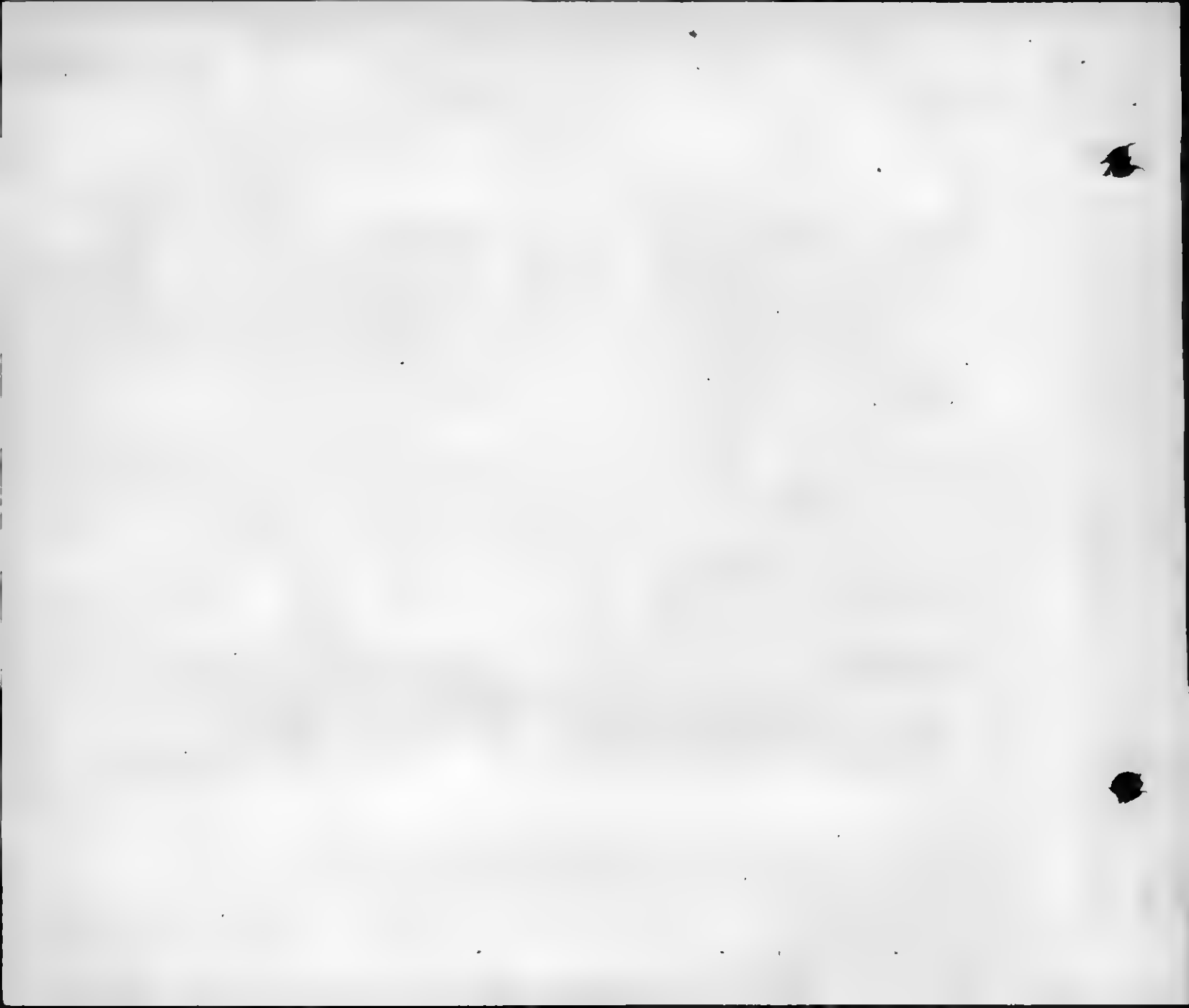
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5835 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05823

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4900 Battery Lane</u>		d. STREET ADDRESS <u>4900 Battery Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph Newman Parks</u>		4. DATE OF DEATH <u>May 30 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1896</u>
9. AGE (in years last birthday) <u>63</u> yrs		10. FUNDING YEAR <u>1959</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Byrd Parks</u>		14. MOTHER'S MAIDEN NAME <u>Alma Healey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW #1</u>		16. SOCIAL SECURITY NO. <u>1-27-48899</u>	
17. INFORMANT <u>Geo Bernard Parks</u>		Address <u>10802 Keller St Silver Spring Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> (c) <u>stroke</u> caused last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>stroke</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		DATE SIGNED <u>5-30-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCH</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be made as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.





5836

## CERTIFICATE OF DEATH

05824

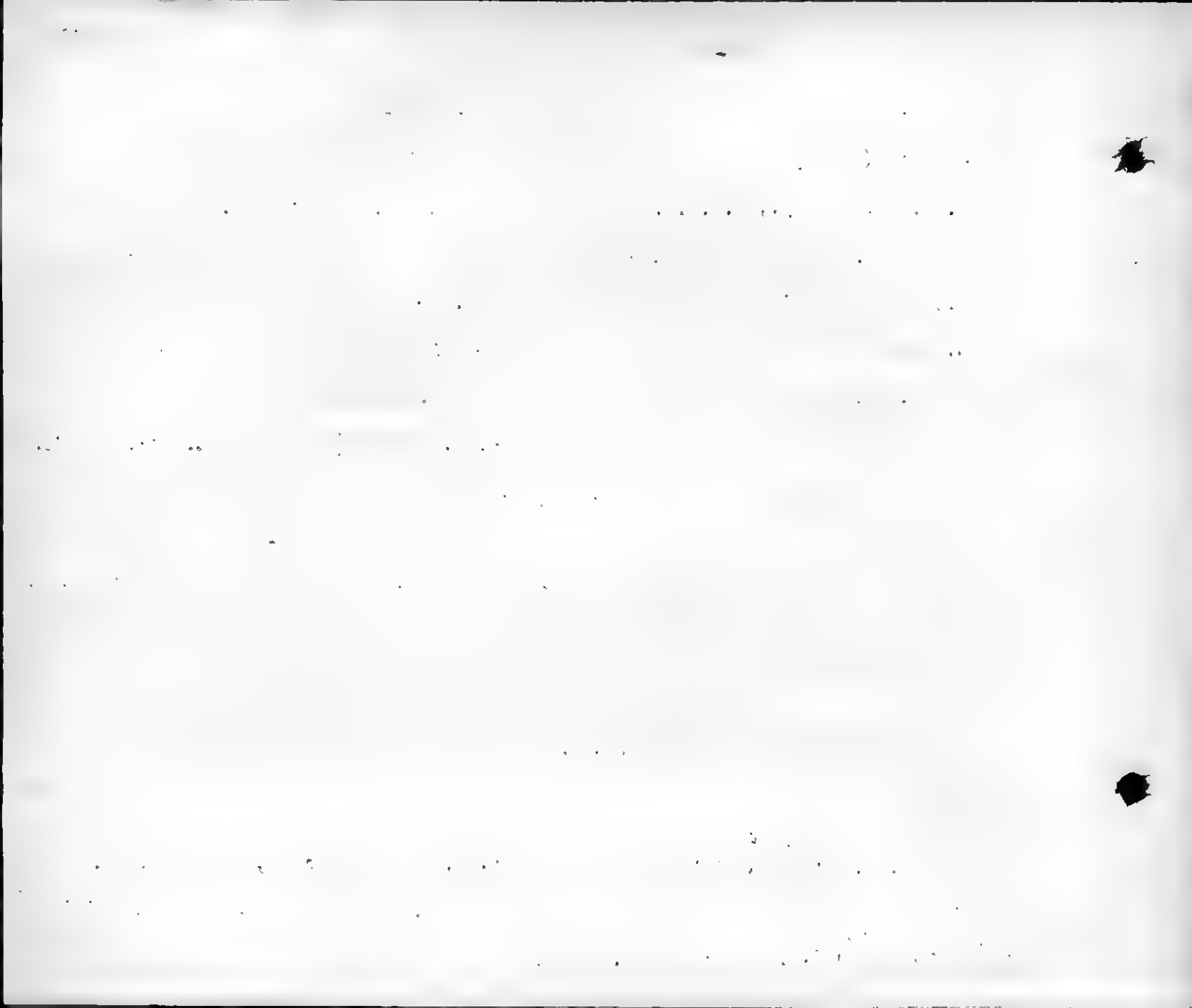
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Arlington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hosp., N.N.M.C.</b>		d. STREET ADDRESS <b>3327 S. Stafford St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Russel</b> Middle <b>Benjamin</b> Last <b>PUTNAM</b>		4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 Jan. 1878</b>
9. AGE (In years lost birthday) yrs. <b>81</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. USMC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Louisiana</b>	
11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James H. PUTNAM</b>		14. MOTHER'S MAIDEN NAME <b>Mary P. JOHNSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW-1</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mabel T. PUTNAM (wife) 3327 S. Stafford St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO (c) <b>Arteriosclerosis, generalized</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>48 hours</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7 Apr.</b> 19 <b>59</b> , to <b>27 May</b> 19 <b>59</b> , that I last saw the deceased alive on <b>29 May</b> 19 <b>59</b> , and that death occurred at <b>1838h</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>[Signature]</i>		M.D.	
PHYSICIAN'S NAME (Type) <b>J. M. YOUNG LT MC USN</b>		<b>U. S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-2-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> <b>Joseph Gawler's &amp; Sons 1756 Penn. Ave WDC</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 3 '59</b>	24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05825

5837

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 35 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d STREET ADDRESS 2230 California St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Satterlee		First Middle Last PYE		4. DATE OF DEATH Month Day Year May 4 19 59			
5 SEX Male	6 COLOR OR RACE Cuacasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-9-80	9 AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Attn	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Minnesota		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James PYE				14 MOTHER'S MAIDEN NAME Clara SATTERLEE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1896 to 1944		16 SOCIAL SECURITY NO.		17 INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver Failure</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatous, submandibular, origin undet.</u> DUE TO (c) <u>4 months</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic heart disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 31, 19 59, to May 4, 19 59, that I last saw the deceased alive on May 4, 19 59, and that death occurred at 8:20P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. E. Richardson		M.D. U. S. Naval Hospital, NMMC		DATE SIGNED 5-5-59			
PHYSICIAN'S NAME (Type) H. E. RICHARDSON, CAPT, MC, USN		Bethesda 14, Maryland					
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE MAY 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5838

## CERTIFICATE OF DEATH

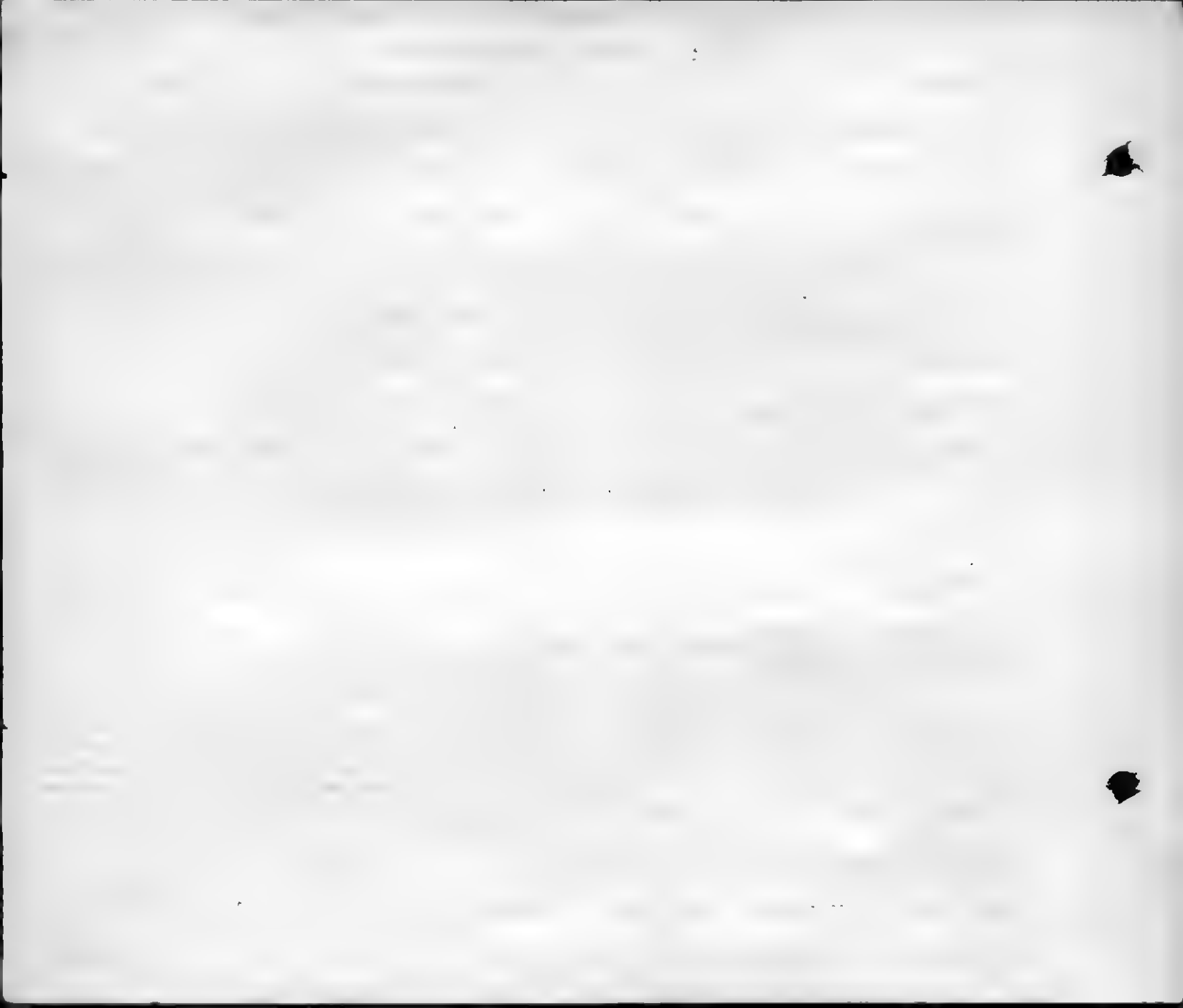
Reg. Dist. No.

05826

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium Bethesda</u>				d. STREET ADDRESS <u>2231 California St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Happersett</u> Last <u>Rees</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 October 1899</u>	9. AGE (In years last birthday) <u>59</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Thomas Henry Rees</u>				14. MOTHER'S MAIDEN NAME <u>Frances Happersett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT (Sister) <u>Mrs. Dorothy Cramer</u> Address <u>2231 California St. N.W. Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma of Lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>5:55</u> p. m. Month <u>5</u> Day <u>5</u> Year <u>1959</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-5</u> , 19 <u>59</u> , to <u>5-5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-5</u> , 19 <u>59</u> , and that death occurred at <u>5:55</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2025 - Eye St., N.W., Wash. D.C.</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>Jerome H. Epstein</u> M.D.				PHYSICIAN'S NAME (Type) <u>Jerome Epstein</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-7-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Myer, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawicki's Sons</u> ADDRESS <u>1756 Pa. Ave. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5839

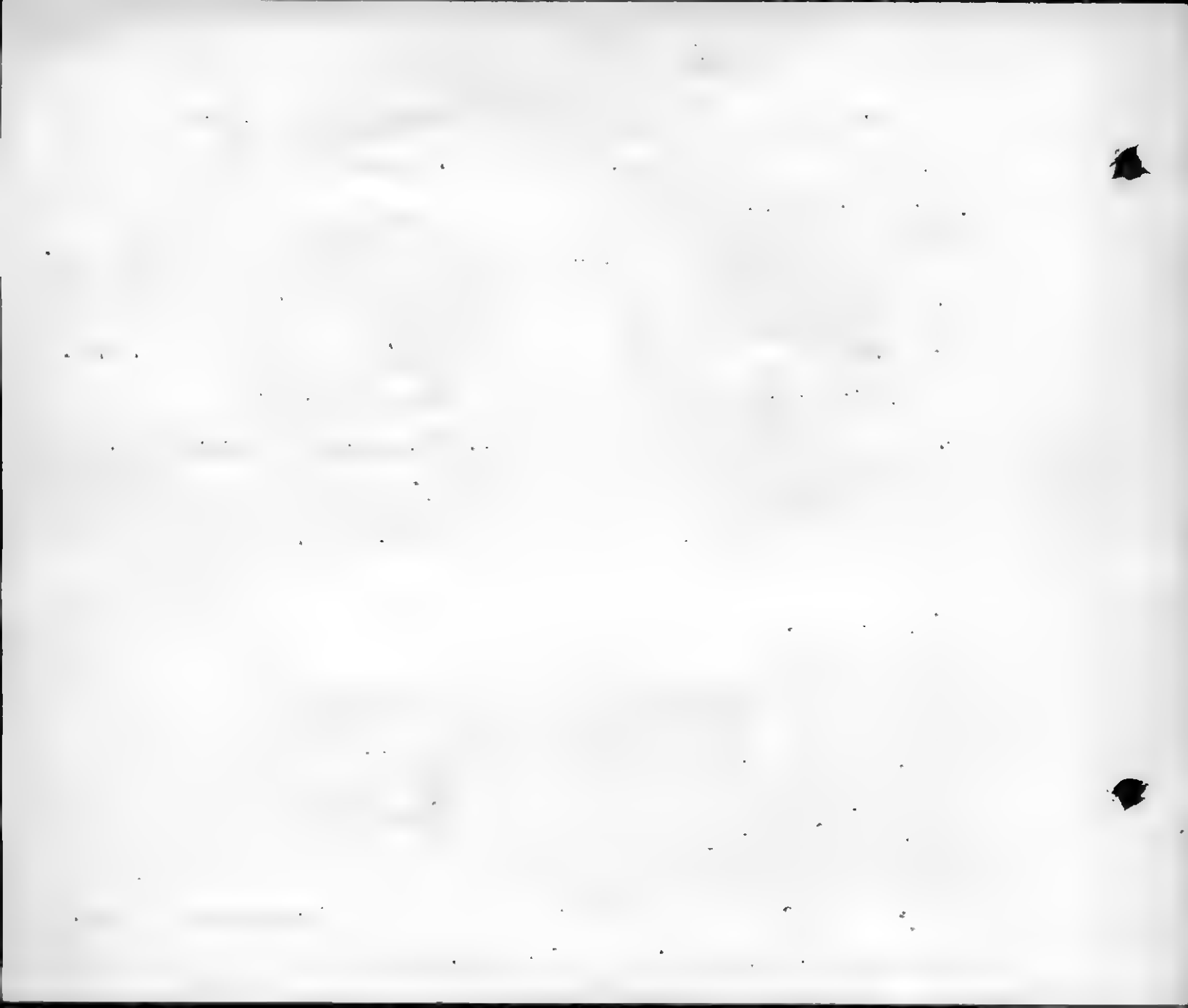
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buck Lodge</b>				c. LENGTH OF STAY IN 1b <b>1 mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Simpson Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clinton</b> Middle <b>Monroe</b> Last <b>Rhodes</b>				4. DATE OF DEATH Month <b>5</b> Day <b>20</b> Year <b>19 59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/9/1875</b>		9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Christian Rhodes</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Buzzard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		INFORMANT <b>Mrs. Flora Rhodes Dickerson, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion, Acute,</b> <b>420.1</b> DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>8 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March, 1953, to 20 May, 1959</b> that I lost the deceased alive on <b>28 May, 1959</b> , and that death occurred at <b>10:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lydia M. Smith</b>				ADDRESS (Street, city or town, state) <b>Barnesville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Constance C. Hilton</b>				DATE SIGNED <b>21 May 59</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Hilton</b>				24a. REC'D BY REGISTRAR <b>MAY 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hunt</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5721 CERTIFICATE OF DEATH

05828

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN 1b <b>1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SANITARIUM</b>				e. STREET ADDRESS <b>14 MANCHESTER PLACE</b>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>JOSEPH</b> Last <b>RITER</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>22</b> Year <b>1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 4, 1912</b>	9. AGE (In years last birthday) <b>46</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHOES</b>		11. BIRTHPLACE (State or foreign country) <b>MASSACHUSETTS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LOUIS RITER</b>				14. MOTHER'S MAIDEN NAME <b>IDA SCHWARTZ</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>LOUIS WAYMAN 5581-CHILLUM PL NE WASHINGTON D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 HOURS</b> <b>4 MONTHS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB 1, 1959</b> to <b>MAY 22, 1959</b> , that I last saw the deceased alive on <b>MAY 22, 1959</b> , and that death occurred at <b>9:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4300 KAYWOOD DRIVE</b> DATE SIGNED <b>MAY 22, 1959</b>							
ACTUAL SIGNATURE <b>Samuel J. Sugar</b> M.D.				PHYSICIAN'S NAME (Type) <b>Samuel J. Sugar</b> <b>MT RAINIER, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-26-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT. CEM.</b>		22d. LOCATION (City, town or county) (State) <b>ARLINGTON, VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Dargatzis</b> ADDRESS <b>3501-14 St NW</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. France</b>	



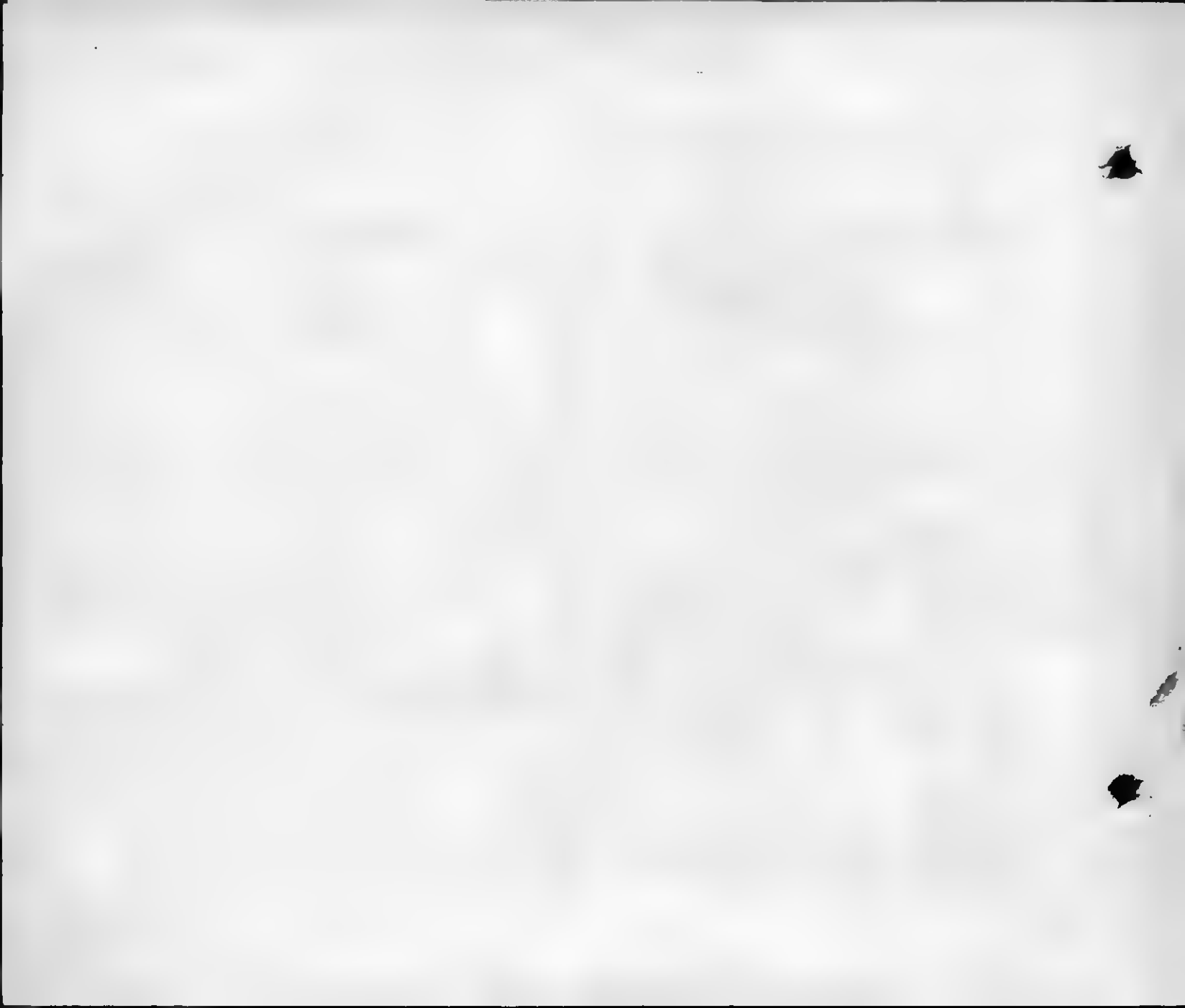
## 5840 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>District of Columbia</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 47x</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium</u>		d. STREET ADDRESS <u>7705 Morningside Drive NW</u>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Shields</u> Last <u>Robinson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Wh. k</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 Feb 1873</u>
9. AGE (In years, last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Shields</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Niece, Mrs. James H. Rees</u> Address <u>7705 Morningside Wash, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Sclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture right hip - operated - Feb 24, 1959</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 2, 1959</u> to <u>May 6, 1959</u> , that I last saw the deceased alive on <u>May 2, 1959</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Havell</u> M.D.		DATE SIGNED <u>5516 Feb. 1959</u>	
PHYSICIAN'S NAME (Type) <u>Robert B. Havell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>May 7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sammons Bros. 1661-9th Ave</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



05830

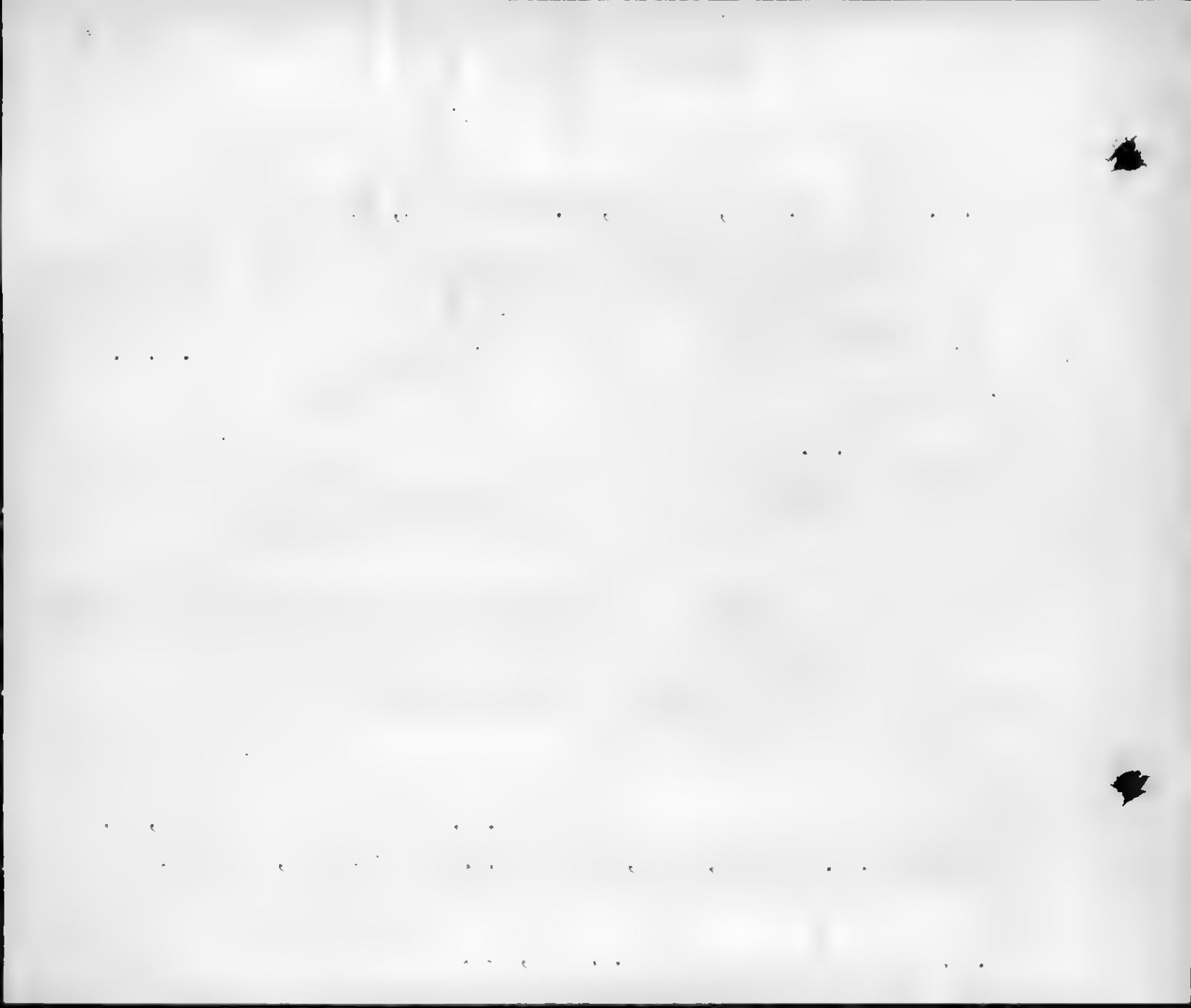
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>12 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hosp. NNMCM, Bethesda, Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Stafford (City)</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stafford</b> d. STREET ADDRESS <b>RFD #4, Box 339</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas Edward ROLLINS</b> First Middle Last 4. DATE OF DEATH Month Day Year <b>May 24 19 59</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>Negroid</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>11-1-87</b> 9. AGE (In years last birthday) <b>71 yrs.</b> IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b> 11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Simond ROLLINS</b> 14. MOTHER'S MAIDEN NAME <b>Susan Ann WHITE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) If yes, give war or dates of service <b>Yes U. S. Army</b> 16. SOCIAL SECURITY NO. <b>U. S. Army</b> 17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RENAL FAILURE (UREMIA)</b> <b>446x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CHRONIC BILATERAL NEPHROSCLEROSIS</b> DUE TO (c) <b>CHRONIC INFECTION AND HYPERTENSION</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b> <b>10 YEARS</b> <b>10 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE &amp; CONGESTIVE FAILURE</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter name of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11 May 19 59</b> to <b>24 May 19 59</b> , that I last saw the deceased alive on <b>24 May 19 59</b> , and that death occurred at <b>0333 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>F. S. CALDWELL</b> ACTUAL SIGNATURE M.D. <b>U. S. NAVAL HOSPITAL, BETHESDA, MD.</b> PHYSICIAN'S NAME (Type) <b>F. S. CALDWELL, LT MC, USN</b> <b>U.S. NAVAL HOSPITAL, BETHESDA, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>5-26-59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>UNIONVILLE CEMETERY</b> 22d. LOCATION (City, town, or county) (State) <b>STAFFORD VIRGINIA</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. JARVIS 1432 "U" STREET N.W. WASH, D.C.</b> 24a. REC'D BY REGISTRAR DATE <b>MAY 26 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be designated for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

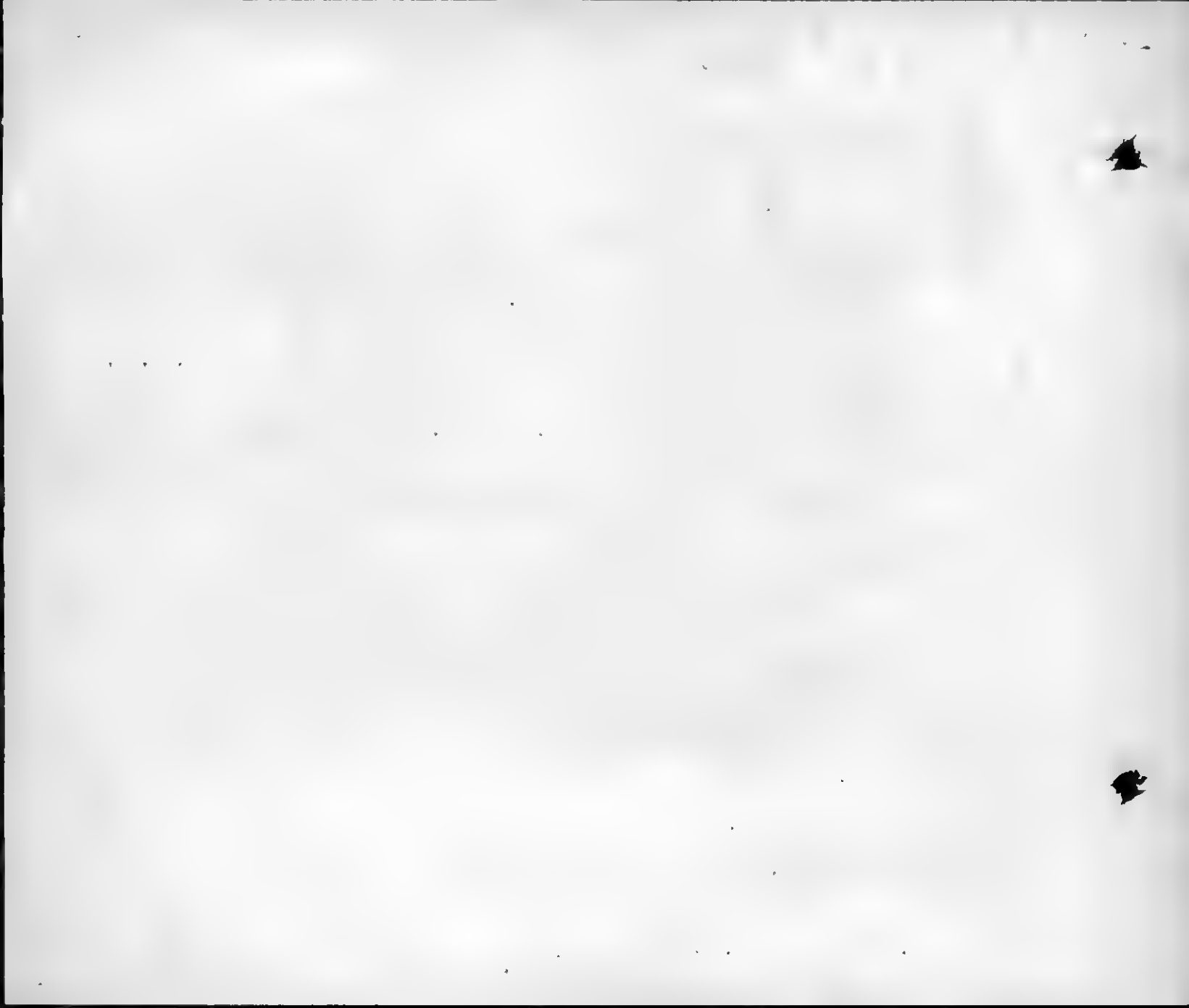
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5842 CERTIFICATE OF DEATH

05831

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u> MD c. LENGTH OF STAY in 1b <u>2 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>1522 LIVE OAK DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Julia ANNA Russell</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>5 31 1959</u>			
<b>5. SEX</b> <u>Fe</u> <b>COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>5/20/73</u>		<b>9. AGE</b> (In years last birthday) <u>86 yrs.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Austria</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Valentine Makre</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Frances Hans</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes no or unknown) <u>no</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO</b> <u>none</u>		<b>17. INFORMANT</b> <u>Mrs. Jesse M. Eader</u> <u>1522 Live Oak Drive, Silver Spring, Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>351X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3-4 d.</u> <u>?</u> <u>?</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I attended the deceased from</b> <u>Oct 1958</u> <b>to</b> <u>31 May 1959</u> <b>that I last saw the deceased alive on</b> <u>30 May 1959</u> <b>and that death occurred at</b> <u>9:42 PM</u> <b>from the causes and on the date stated above.</b>							
<b>ACTUAL SIGNATURE</b> <u>William D. Aud</u> M.D.				<b>ADDRESS</b> (Street, city or town, state) <u>906 Lakeside Rd Silver Spring, Md</u>		<b>DATE SIGNED</b> <u>5/31/59</u>	
<b>PHYSICIAN'S NAME (Type)</b> <u>WILLIAM D. AUD</u>				<b>Silver Spring, Md</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>6/3/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>New Cathedral Cemetery</u>		<b>22d. LOCATION (City, town, or county) (State)</b> <u>Baltimore, Maryland</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>				<b>ADDRESS</b> <u>8434 Georgia Avenue Silver Spring, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE JUN 2 '59</u>	
				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Evans</u>			





Reg. Dist. No.

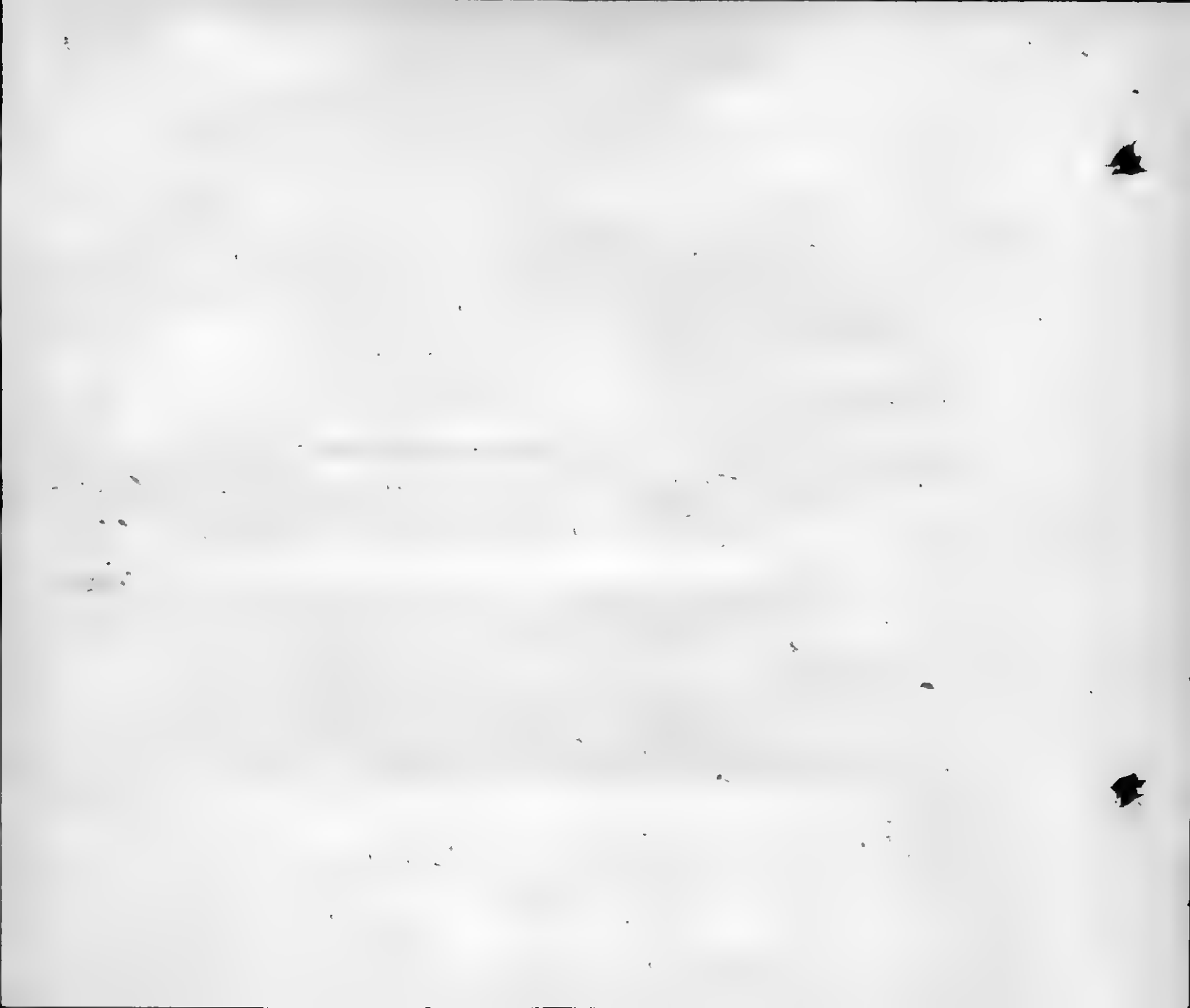
# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>6406 Western Avenue</b>		d. STREET ADDRESS <b>6406 Western Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH M. SCHLAUDECKER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>31</b> , Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1870</b>
9. AGE (In years last birthday) <b>89</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>18</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Erie, Pa.</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>Frank H. Hoffmann</b>		14. MOTHER'S MAIDEN NAME <b>Kathryn ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>John A. Schlaudecker-Item # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> DUE TO <b>Arterio-sclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10 yr</b> DUE TO (c) <b>18 yr</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus - 18 yr</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>24 Nov 1956</b> to <b>31 May 1959</b> , that I last saw the deceased alive on <b>30 May 1959</b> , and that death occurred at <b>12:12 M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>A. H. Richwine</b> M.D. <b>5522 Western Ave</b> PHYSICIAN'S NAME (Type) <b>A. H. RICHWINE</b> <b>Cheng chow is not</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>ur Transit</b>	<b>5/31/59</b>	<b>Trinity</b>	<b>Erie, Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 2 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5722

## CERTIFICATE OF DEATH

Reg. Dist. No. 05833

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>60 University Blvd. E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Regina</u> Last <u>Schelle</u>		4. DATE OF DEATH Month <u>5</u> - Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-6-21</u>
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR: Months <u>3</u> Days <u>16</u> Hours <u>16</u> Min. <u>37</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>BURKHAMMER</u>		14. MOTHER'S MAIDEN NAME <u>Florence Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>168-20-4982</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - metast. prob. in CNS</u> DUE TO <u>155.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Colon</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 mths 2 mo. 2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 12, 1943</u> , to <u>16 May, 1959</u> , that I last saw the deceased alive on <u>15 May, 1959</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. P. McNeill</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave.</u> DATE SIGNED <u>5/16/59</u>	
PHYSICIAN'S NAME (Type) <u>W. P. McNeill, M.D.</u>		<u>Takoma Park 12, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 19 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

5844

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

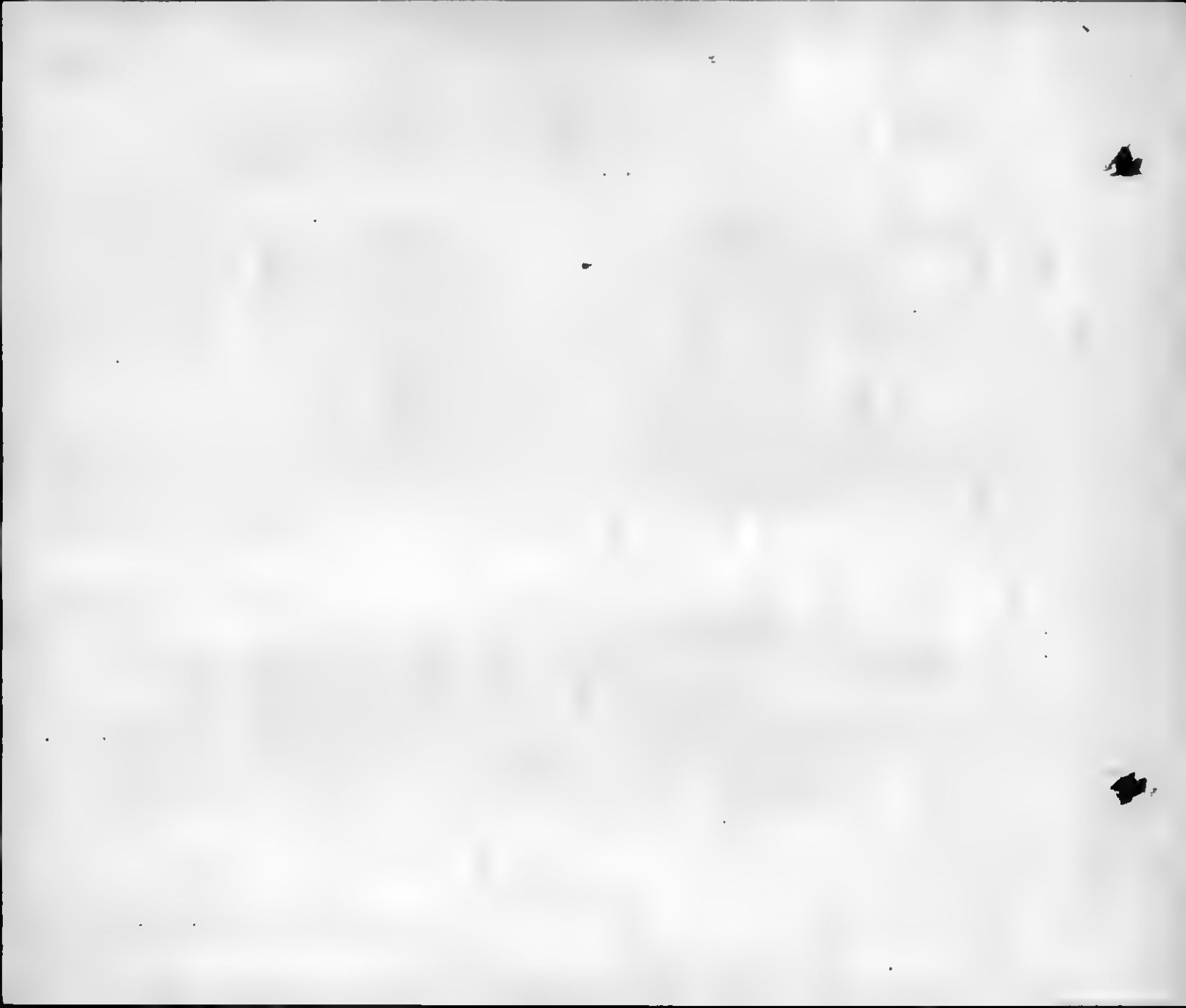
Reg. Dist. No. 15834

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>221 Deer Park Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Otis</u> Middle <u>Grant</u> Last <u>Shipe</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/19/1899</u>
9. AGE (In years not birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>John Hopkins Lab</u>		<u>Berlinton, Virginia</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>U.S.A</u>		<u>U.S.A</u>	
13. FATHER'S NAME <u>Benjamin Shipe</u>		14. MOTHER'S MAIDEN NAME <u>Dora Moyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Wife (Same as Above)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Amputation of brain stem</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Fracture of skull</u> DUE TO (c) <u>Fractures of C-1 &amp; C-2 with compression of cord</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple injuries, extreme</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Driver of auto involved in head on collision</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:15 a.m. 5/2/59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>	20f. (City or town) (County) (State) <u>nr Gaithersburg Montg. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/6/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>MAY 5 '59</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

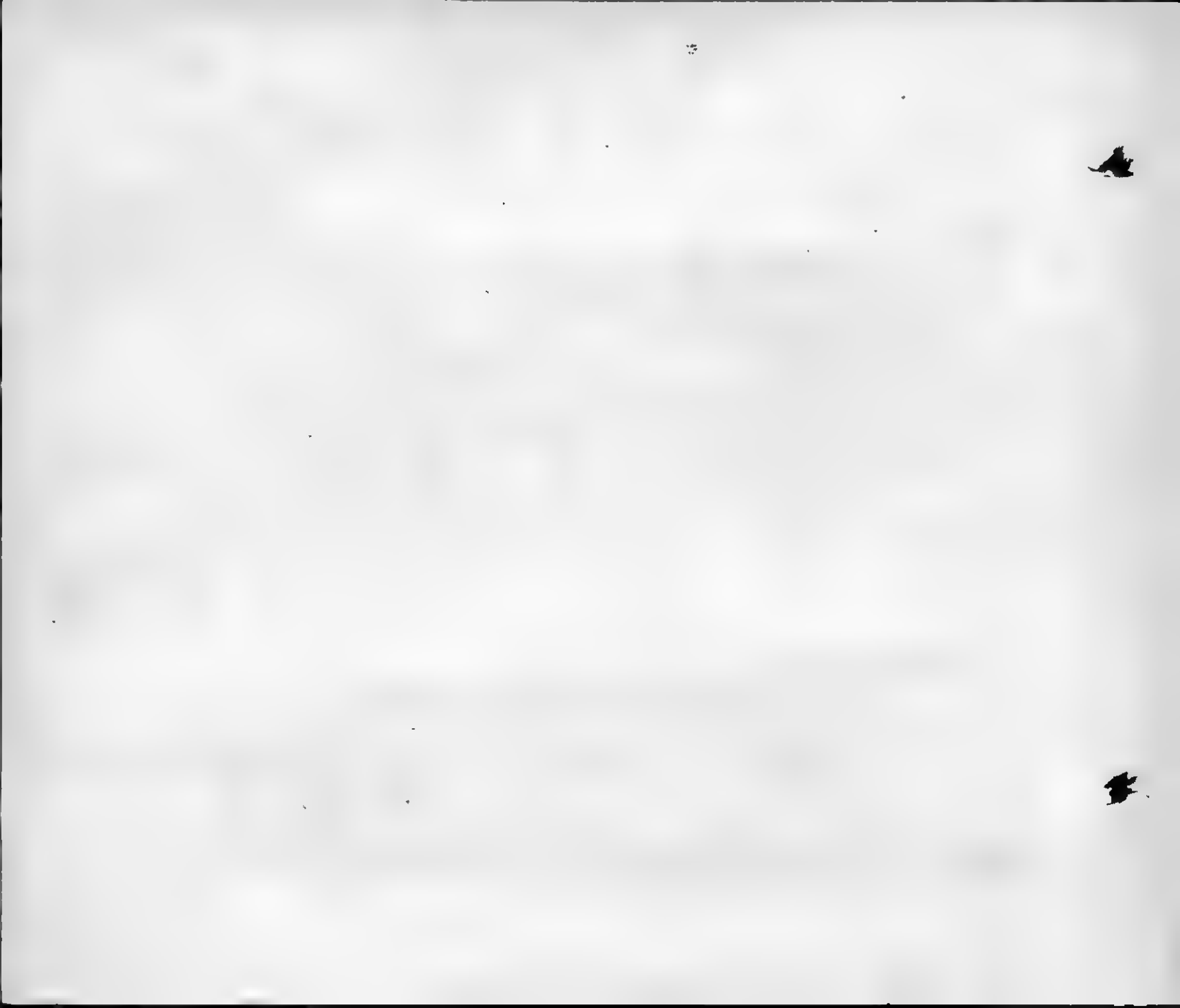
VS. A15ME  
SM 2/57

Brought in 8:15 A.M. by Rockville Rescue Squad D.O.A

TO DEPUTY MEDICAL EXAMINER: This certificate should be filed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.









**5723 CERTIFICATE OF DEATH**

Reg. Dist. No. **05836**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>	
c. LENGTH OF STAY IN 1b <b>6 days</b>		1617-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington San &amp; Hosp.</b>		d. STREET ADDRESS <b>1118 Lancaster Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Frances Isabel Small</b>		4. DATE OF DEATH <b>5 22 1959</b>	
5. SEX <b>100% fe.</b> 6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>4/29/12</b>		9. AGE (In years last birthday) <b>47</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles Olen Heavenex</b>		14. MOTHER'S MAIDEN NAME <b>Addie Sullivan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>PT's hosp. Record</b>	
17. INFORMANT <b>PT's hosp. Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Glottanoma Multiforme (ectocystoma Grade 3)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>et 9 days</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 29, 1959</b> to <b>May 22, 1959</b> , that I last saw the deceased alive on <b>May 22, 1959</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leo J. Schildhaus</b>		ADDRESS (Street, city or town, state) <b>6101 New Hampshire Ave. Wash. D.C.</b>	
PHYSICIAN'S NAME (Type) <b>Leo J. Schildhaus</b>		DATE SIGNED <b>5/22/59</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. H. Hines Co.</b>		ADDRESS <b>2901-14 St. N.W.</b>	
24a. REC'D BY REGISTRAR <b>DATE 5/27/59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 25 '59



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

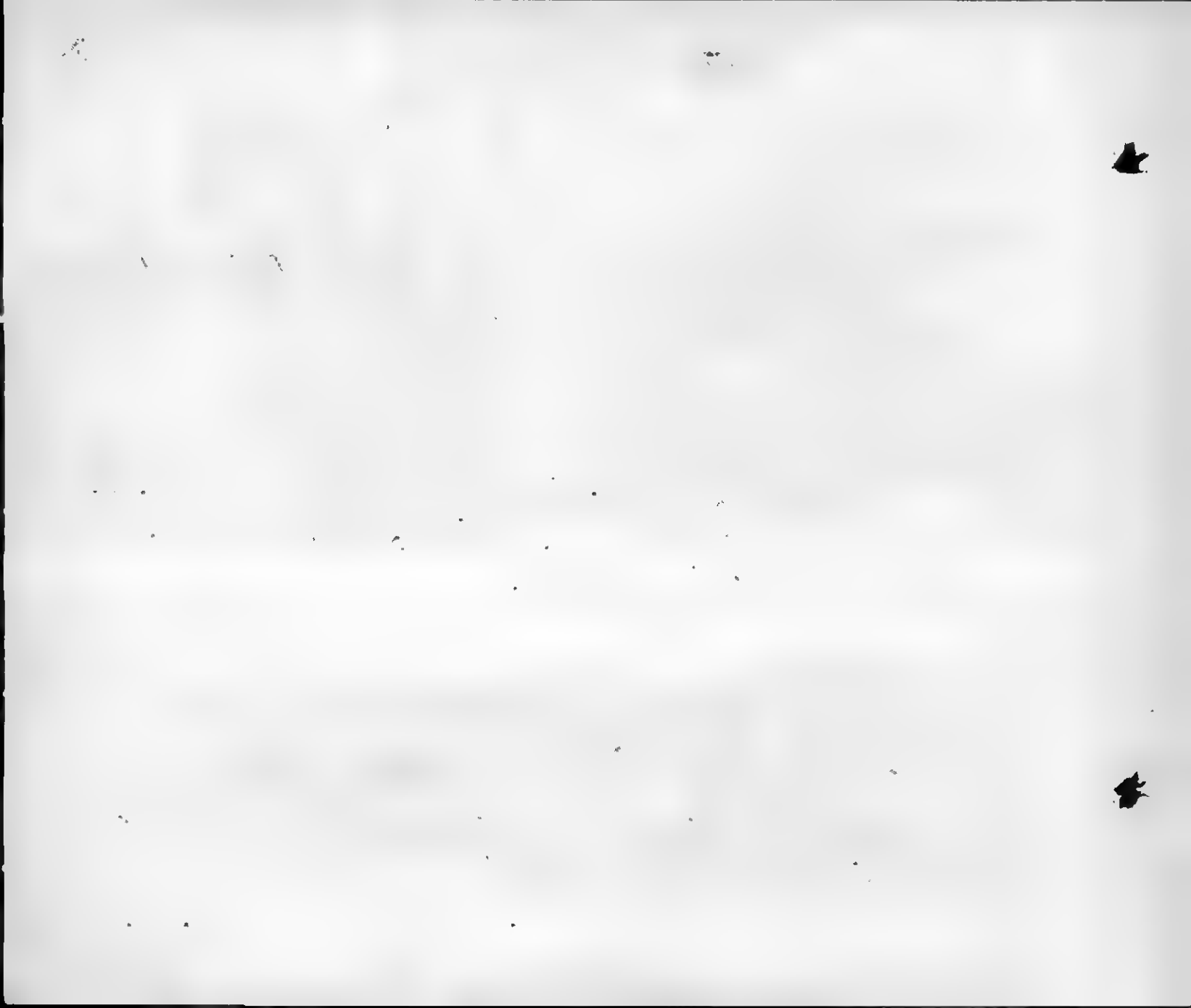
5846 CERTIFICATE OF DEATH

Reg. Dist. No.

05837

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Wilcox Smith</u>				4. DATE OF DEATH Month Day Year <u>MAY 31 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 9, 1876</u>	
9. AGE (In years, last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Littleton Smith</u>				14. MOTHER'S MAIDEN NAME <u>Suzanna Perry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Asbury Methodist Home Gaithersburg</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO (b) <u>cerebral vascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5-20-59</u> <u>5-11-59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-3</u> 19 <u>58</u> to <u>May 31</u> 19 <u>59</u> , that I last saw the deceased alive on <u>5-27</u> 19 <u>59</u> , and that death occurred at <u>12:55 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10128 CEDAR LANE KENSINGTON, MD</u> DATE SIGNED <u>5-31-59</u>							
ACTUAL SIGNATURE <u>Sarah E Glover</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Sarah Elizabeth Glover</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker &amp; Sons - Balto 17 Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Kenna</u>	

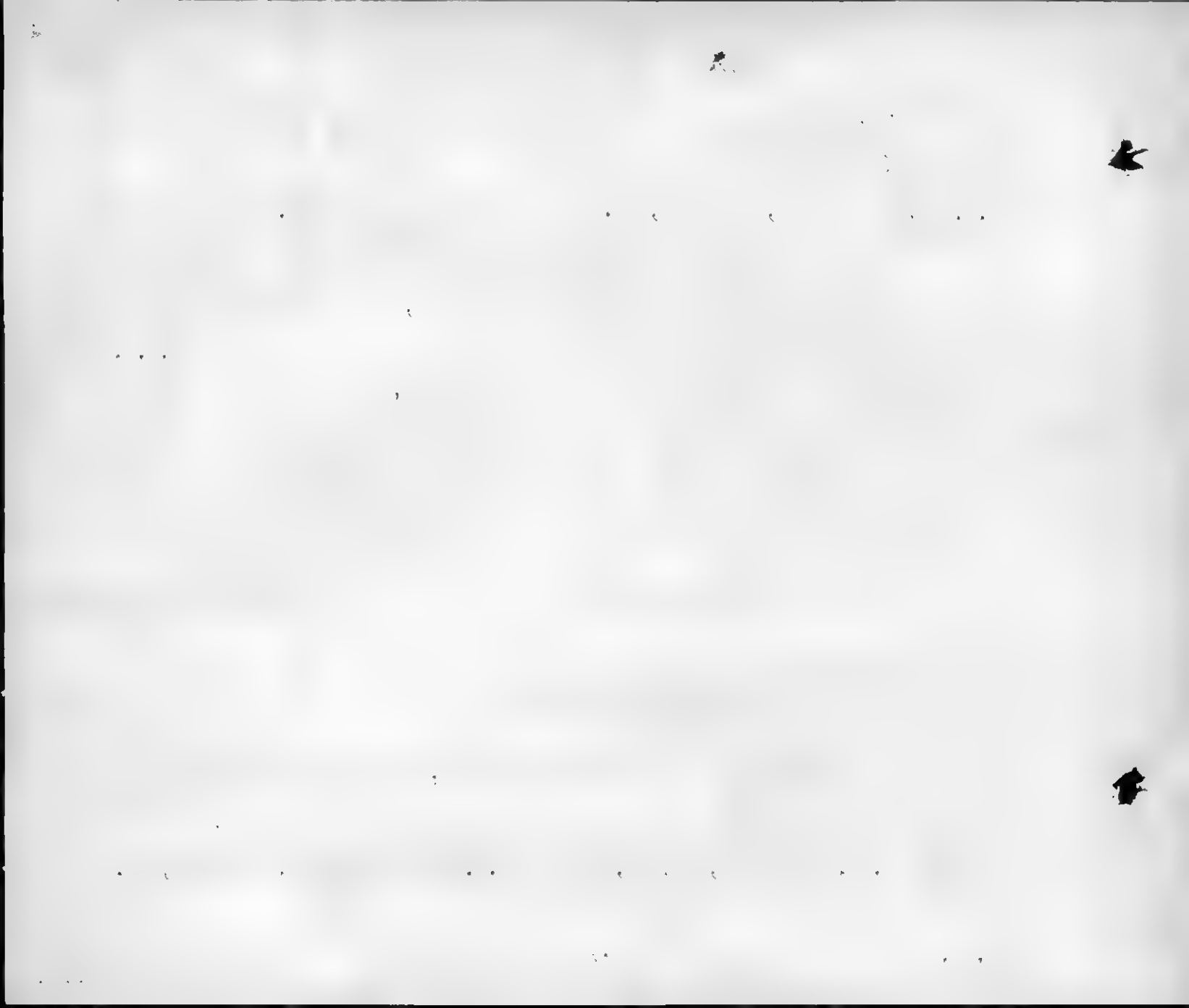
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 05838

MEDICAL CERTIFICATE CATION

VS A15 (4)  
15M 10/57



5848

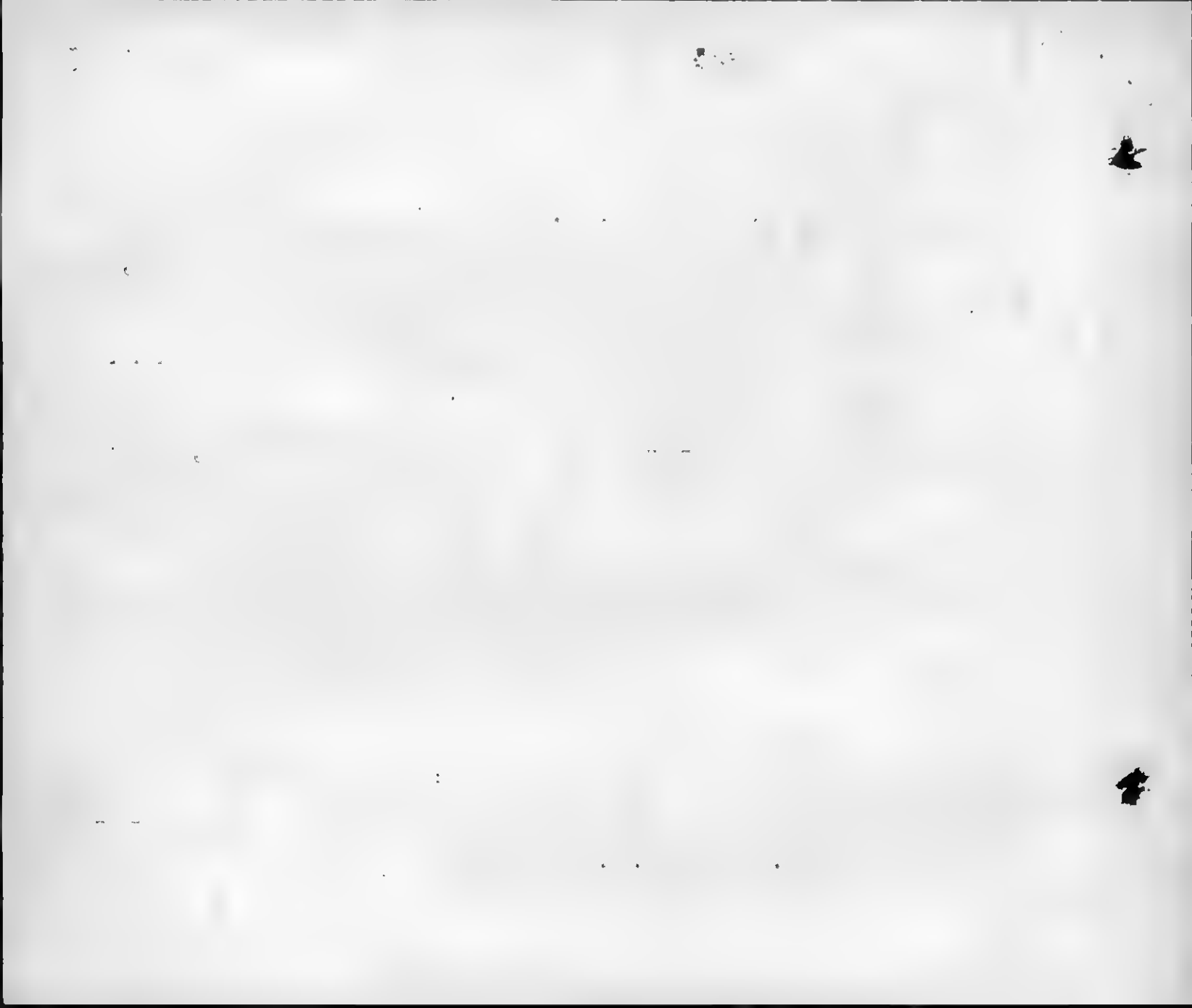
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>590 North Sixth Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Shirley May Smith</b>				4. DATE OF DEATH Month Day Year <b>May 10, 19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 15, 1933</b>	
9. AGE (In years last birthday) <b>25</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13. FATHER'S NAME <b>Joseph Smith</b>				14. MOTHER'S MAIDEN NAME <b>Mae O'Neill</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>135-26-9626</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Ventricular septal defect with congestive failure and intrathoracic hemorrhage (post-operative)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH minutes</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 26, 19 59</b> , to <b>May 10, 19 59</b> , that I last saw the deceased alive on <b>May 10, 19 59</b> , and that death occurred at <b>2:18a</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William P. Cornell</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>5-10-59</b>			
PHYSICIAN'S NAME (Type) <b>William P. Cornell, M. D.</b>				The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>5/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		22d. LOCATION (City, town, or county) (State) <b>Manassas N</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Chamberlain</b>				ADDRESS <b>1400 N. Capital St. N.W.</b>			
24a. REC'D BY REGISTRAR DATE <b>MAY 12 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinner</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





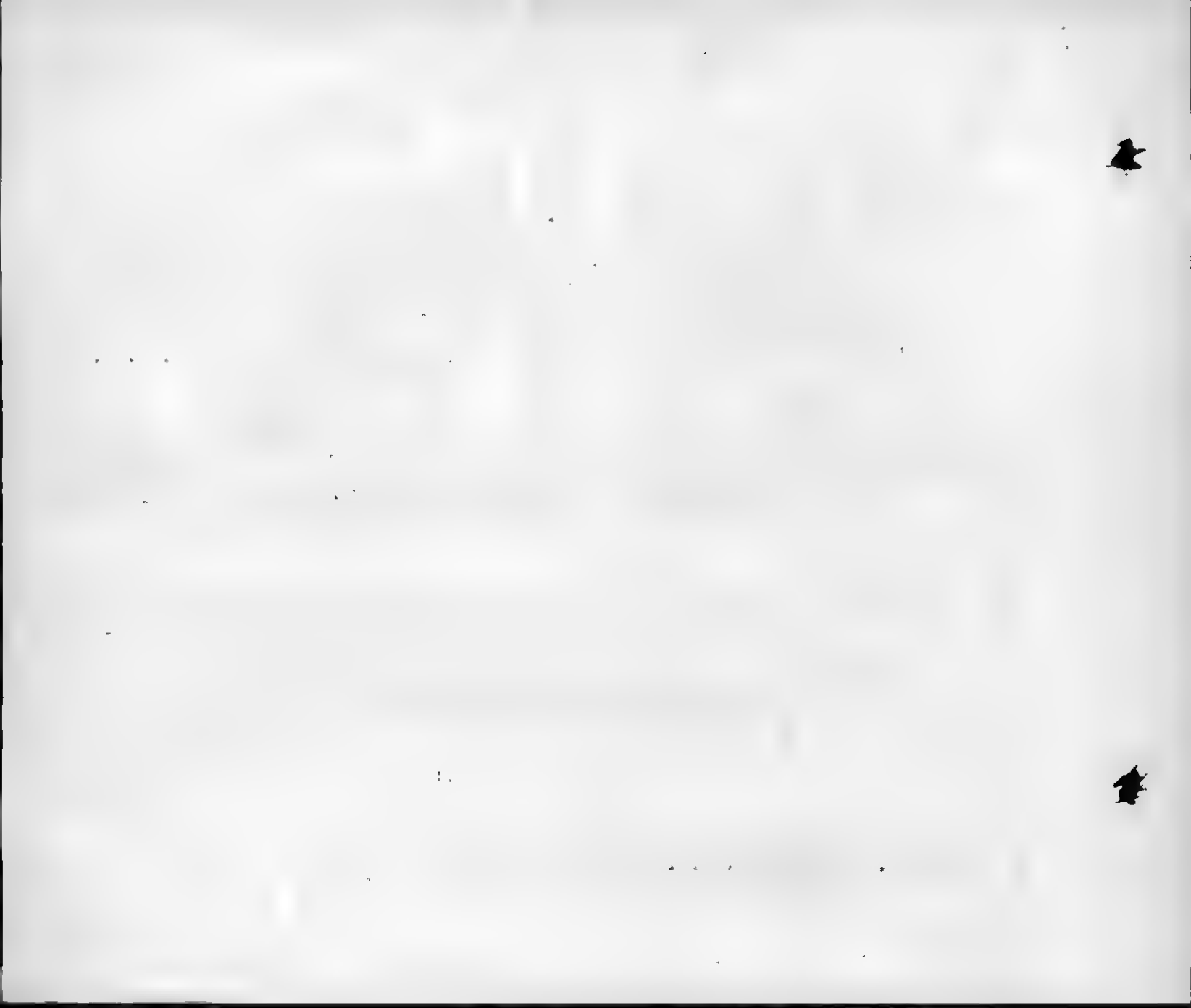
1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**5849 CERTIFICATE OF DEATH**

Reg. Dist. No. **05840**

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN IT <b>5 days</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Philadelphia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>75 x 3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Tillie (none) Snyderman</b>		4. DATE OF DEATH Month Day Year <b>May 11, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 8, 1890</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator's Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ladies' Clothing</b>	
11 BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Gabriel Snyderman</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Forman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>Not available</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Synovionia Metastatic to Lungs</b> 1077 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>2 Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>May 11 1959</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 6</b> , 19 <b>59</b> , to <b>May 11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 11</b> , 19 <b>59</b> , and that death occurred at <b>7:45 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. Richard Lee</i>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5/12/59</b>	
PHYSICIAN'S NAME (Type) <b>G. RICHARD LEE, M.D.</b>		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/13-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Har. Hebo</b>	22d. LOCATION (City, town, or county) (State) <b>Philadelphia Pa</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home Wash DC</i>		24a. REC'D BY REGISTRAR DATE <b>MAY 13 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Huns</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

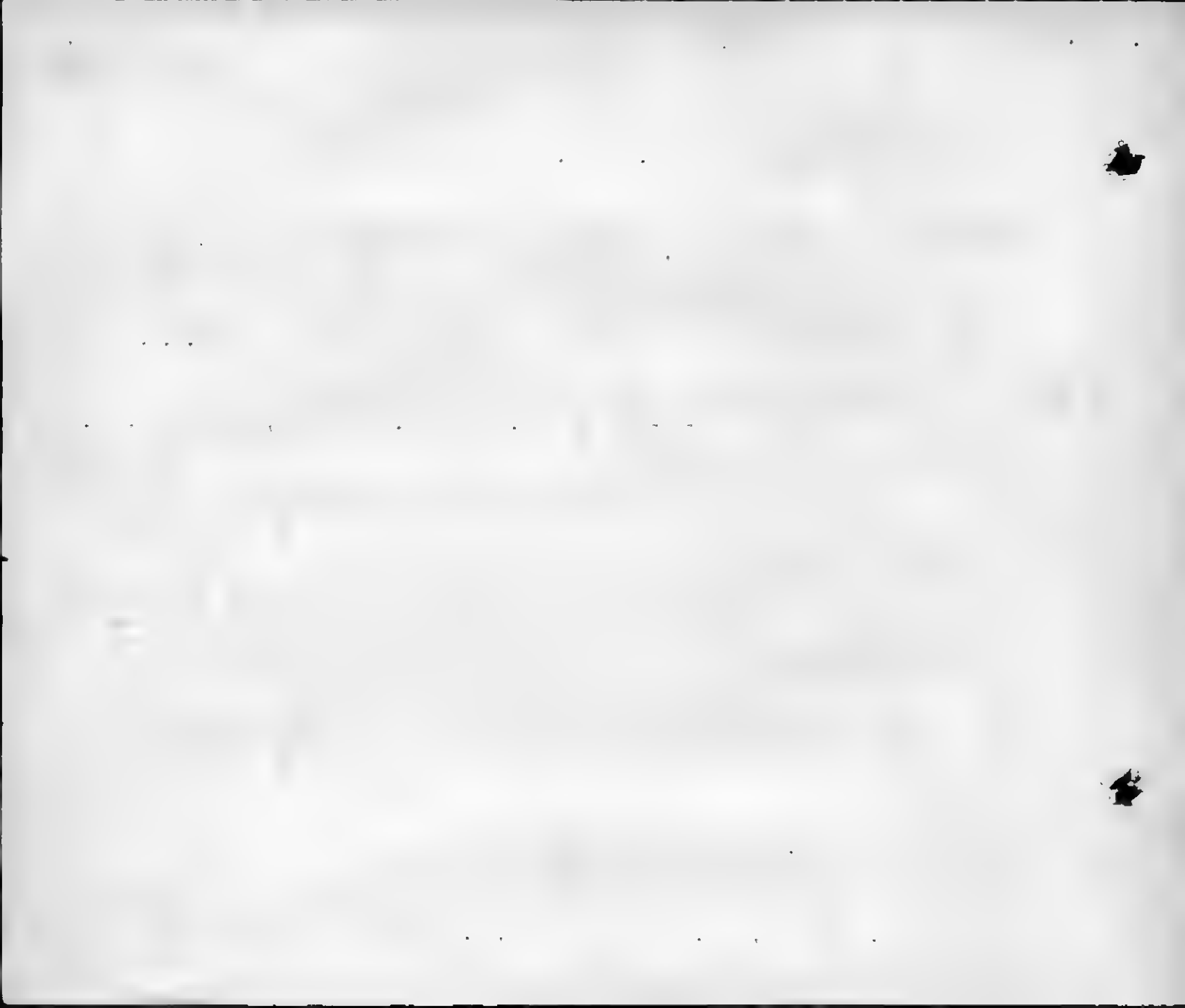
5850

CERTIFICATE OF DEATH

Reg. Dist. No. 05841

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLARKSBURG</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLARKSBURG</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>J.</b> Last <b>Stanowsky</b>				4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/9/87</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER (retired)</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JULIUS HENRY STANOWSKY</b>				14. MOTHER'S MAIDEN NAME <b>MARY LOUISE REX</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577-07-4241</b>		17. INFORMANT Address <b>Mrs. Minnie C. Stanowsky, Clarksburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/15, 1958</b> to <b>5/20, 1959</b> , that I last saw the deceased alive on <b>5/18, 1959</b> , and that death occurred at <b>8:10 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James D. Kerr</b>				ADDRESS (Street, city or town, state) <b>Womansens, Md.</b>		DATE SIGNED <b>5/20/59</b>	
PHYSICIAN'S NAME (Type) <b>JAMES D. KERR</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
				24a. REC'D BY REGISTRAR DATE <b>MAY 22 '59</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5851

## CERTIFICATE OF DEATH

05842

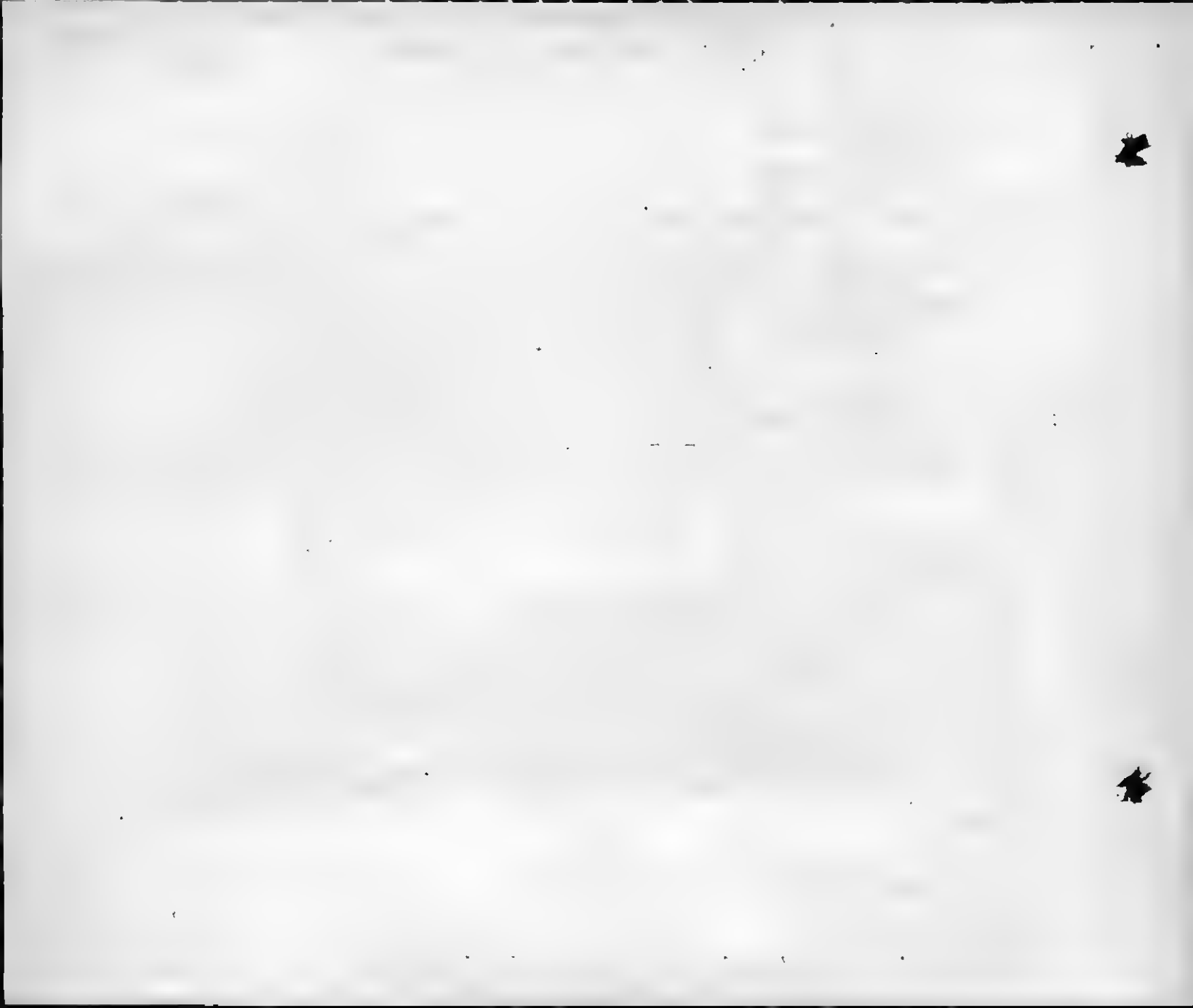
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp-</u>				d. STREET ADDRESS <u>17505-Brookville Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Miller B. Stevenson</u>				4. DATE OF DEATH Month Day Year <u>May 17 1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28-1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Anson &amp; Gilker Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Christopher S. Stevenson</u>				14. MOTHER'S MAIDEN NAME <u>Sara. unknown xxx</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-01-1781</u>			
17. INFORMANT <u>John R. Blake</u> Address <u>1732 Taylor St. N.W. Washington D.C.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>Chronic Glomerulonephritis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>48 days</u> <u>7 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>home</u> <u>1958</u> to <u>17 May, 1959</u> that I last saw the deceased alive on <u>13 May</u> , 19 <u>59</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.				ADDRESS (Street, city or town, state) <u>Olney, Md.</u>			
DATE SIGNED <u>17 May 59</u>							
PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5852

# CERTIFICATE OF DEATH

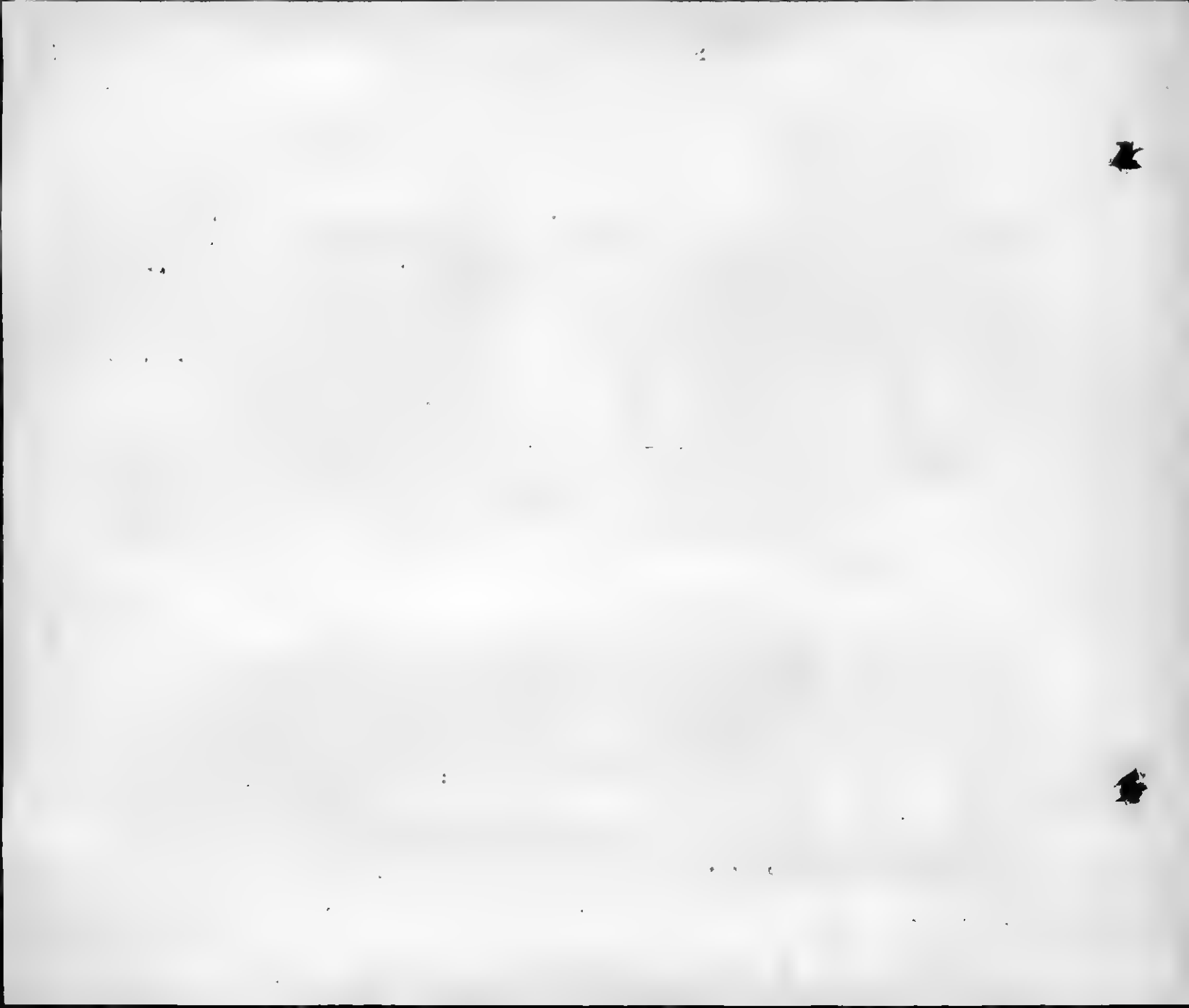
05843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>96 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>76 Forrester Street, S. W.</b>			
3. NAME OF DECEASED (Type or print) <b>Francis</b>		First <b>Glionleau</b>		Middle <b>Steward, Jr.</b>		Last	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>19 59</b>	
9. AGE (In years last birthday) <b>44 yrs</b>		10. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		11. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		13. KIND OF BUSINESS OR INDUSTRY <b>Apartment Upkeeping</b>		14. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		15. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
16. FATHER'S NAME <b>John Steward</b>		17. MOTHER'S MAIDEN NAME <b>Mary E. Shaw</b>		18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		19. SOCIAL SECURITY NO. <b>577-24-6486</b>	
20. INFORMATION The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: <b>331x</b> IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>  <b>Years</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a. m.</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 5</b> , 19 <b>59</b> , to <b>May 12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 12</b> , 19 <b>59</b> , and that death occurred at <b>5:34 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>5/12/59</b>							
ACTUAL SIGNATURE <b>Edgar Haber</b>		M.D. <b>The Clinical Center</b>					
PHYSICIAN'S NAME (Type) <b>EDGAR HABER, M.D.</b>		<b>The National Institutes of Health</b>					
<b>Bethesda 14, Maryland</b>							
22a. BURIAL CREMATION OR REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-15-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>FT. MYER, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Hines</b>		ADDRESS <b>414-15th St. S.E.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	
<b>WASH. D.C.</b>							

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

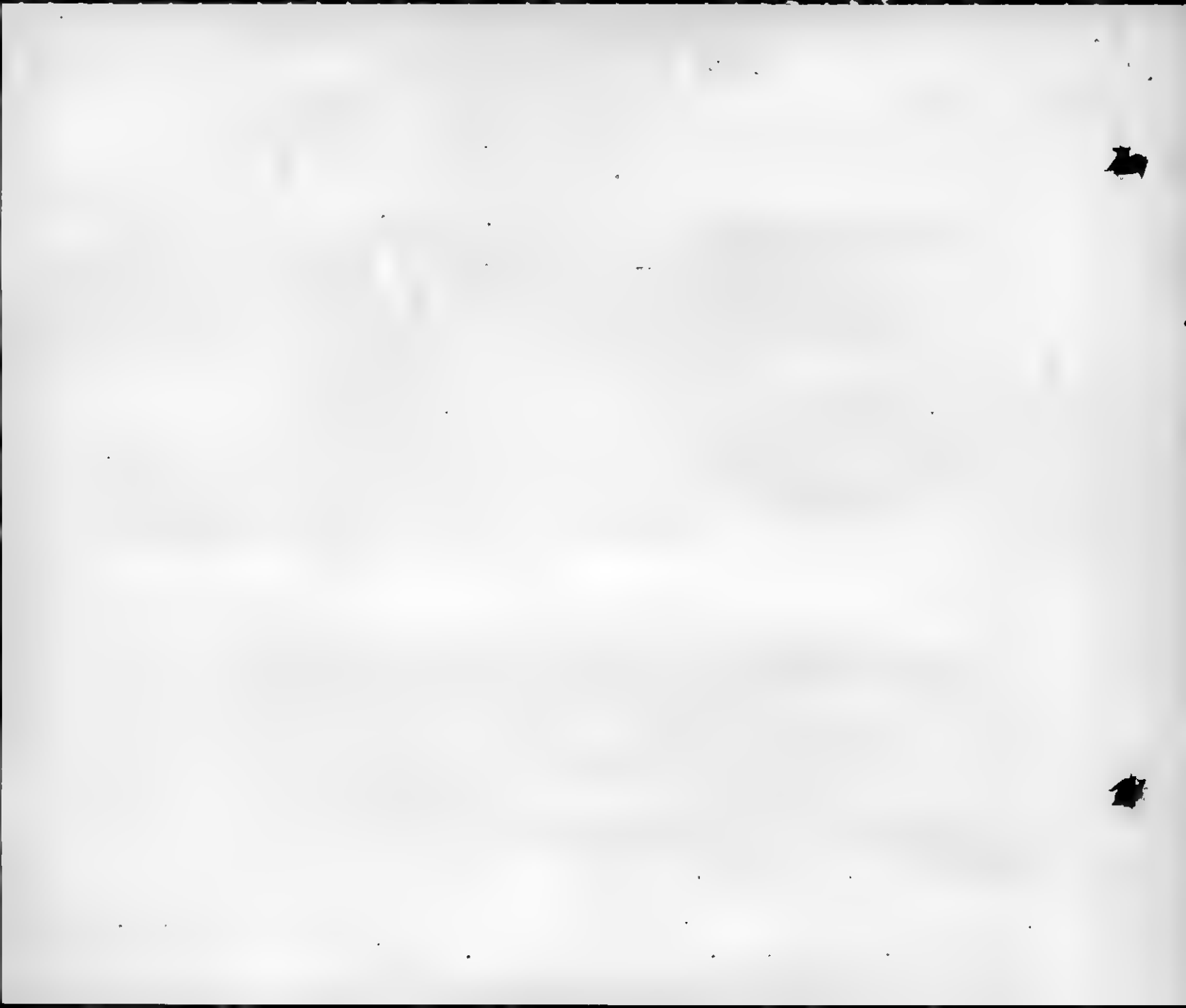
## 5853 CERTIFICATE OF DEATH

Reg. Dist. No.

05844

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>10 MIN.</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>Rt. #1 Homecrest Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY -- STRICKLAND</b>		4. DATE OF DEATH Month Day Year <b>MAY 24 19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 24, 1959</b>
9. AGE (In years last birthday) yrs <b>10</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEWBORN</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>HAROLD WADE STRICKLAND</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN MARY SMITH</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> DUE TO <b>19 wks gestation - 11 oz. weight.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>19 wks gestation - 11 oz. weight.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 24, 1959</b> , to <b>MAY 24, 1959</b> , that I last saw the deceased alive on <b>MAY 24, 1959</b> , and that death occurred at <b>12:35 A.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>5/25/59</b>			
ACTUAL SIGNATURE <b>Richard A. Yates</b> NAME (Type) <b>R. A. YATES, M. D.</b>		M. D. <b>OLNEY, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/27/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5854

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WASHINGTON</b> b. COUNTY <b>D.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON D.C.</b>			
c. LENGTH OF STAY in 1b <b>4 MONTHS</b>				d. STREET ADDRESS <b>38 MILMARSON PL. N.W.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROPINE NURSING HOME; River Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>E.</b> Last <b>TAYLOR</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>31</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 JAN 1859</b>		9. AGE (In years last birthday) <b>100</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>R.M. STRICKBOTT</b> Address <b>9919 Logan Drive</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Vascular Disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>29 Jan</b> , 19 <b>59</b> , to <b>31 May</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>29 May</b> , 19 <b>59</b> , and that death occurred at <b>6:05 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2029 Que St., N.W.</b> DATE SIGNED <b>5-31-59</b>							
ACTUAL SIGNATURE <b>W. F. Cresswell Jr.</b> M.D.				DATE SIGNED <b>2029 Que St., N.W. 5-31-59</b>			
PHYSICIAN'S NAME (Type) <b>W. F. Cresswell</b>				ADDRESS <b>WASHINGTON D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FALMOUTH CREEK</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>DEAL FUNERAL HOME</b>				ADDRESS <b>WASHINGTON D.C.</b>		24a. REC'D BY REGISTRAR <b>24b. REGISTRAR'S SIGNATURE</b>	
DATE <b>JUN 3 '59</b>				ADDRESS <b>4812 GA. AVE. NW</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



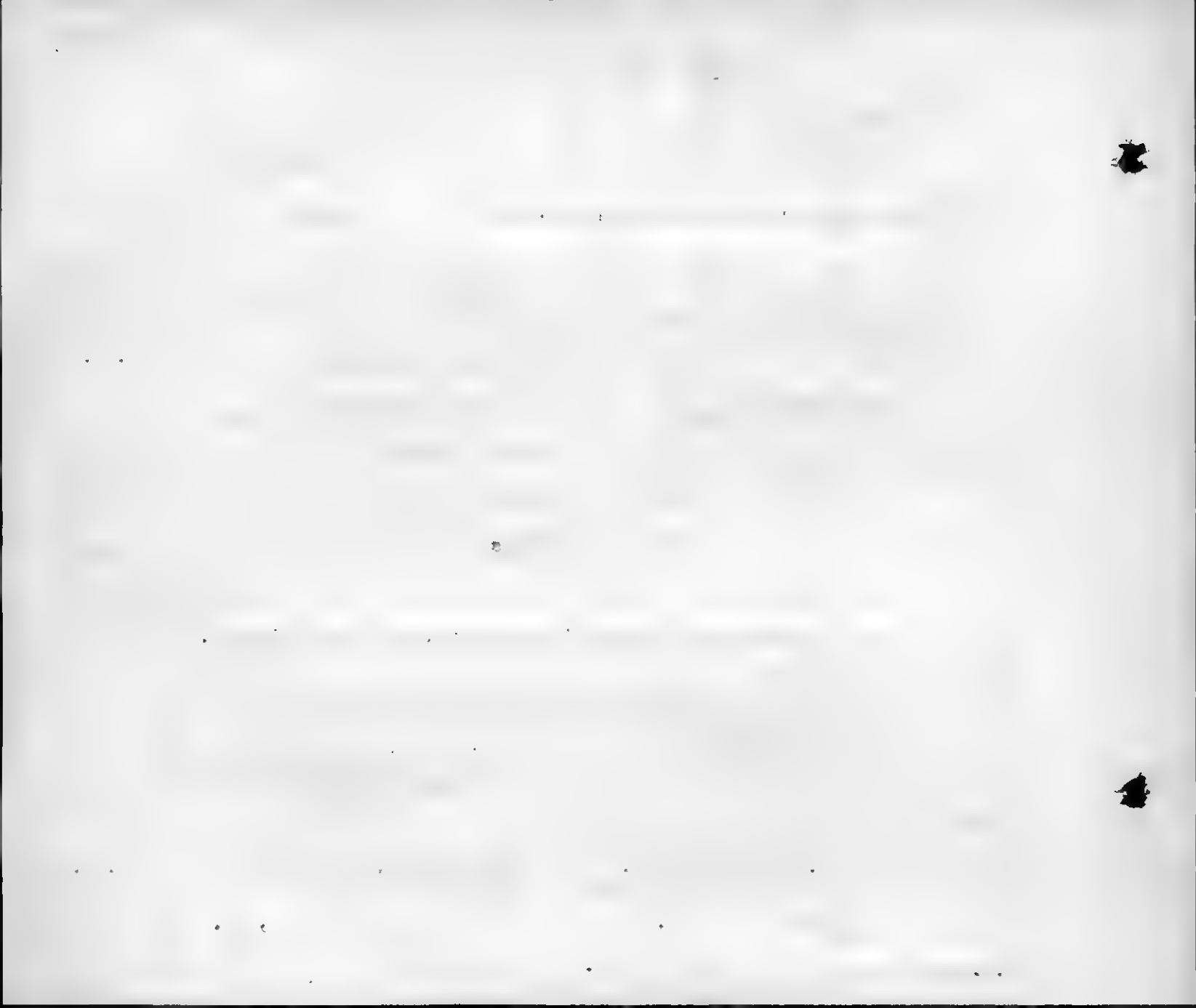
## 5855 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				d. STREET ADDRESS <b>Route #2</b>			
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>Holton</b> Last <b>Thompson</b>				4. DATE OF DEATH Month <b>May</b> 13 Day <b>19</b> Year <b>59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-28-88</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Isaac Iglehart</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Stansfield</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Ruptured Thoracic aneurysm OF AORTA</b> <b>4 IX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thoracic aneurysm OF AORTA</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>5 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive arteriosclerotic cardiovascular renal disease.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>JULY</b> , 1947, to <b>MAY 12</b> , 1959, that I last saw the deceased alive on <b>MAY 12</b> , 1959, and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Charles S. Whitaker</b> M.D.				DATE SIGNED <b>5.13.59</b>			
PHYSICIAN'S NAME (Type) <b>C. S. Whitaker, M. D.</b>				ADDRESS <b>Clarksville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		22d. LOCATION (City, town, or county) (State) <b>Alpha, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higginbotham</b> ADDRESS <b>Ellicott City, Md.</b>				24a. REC'D BY REGISTRAR <b>MAY 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

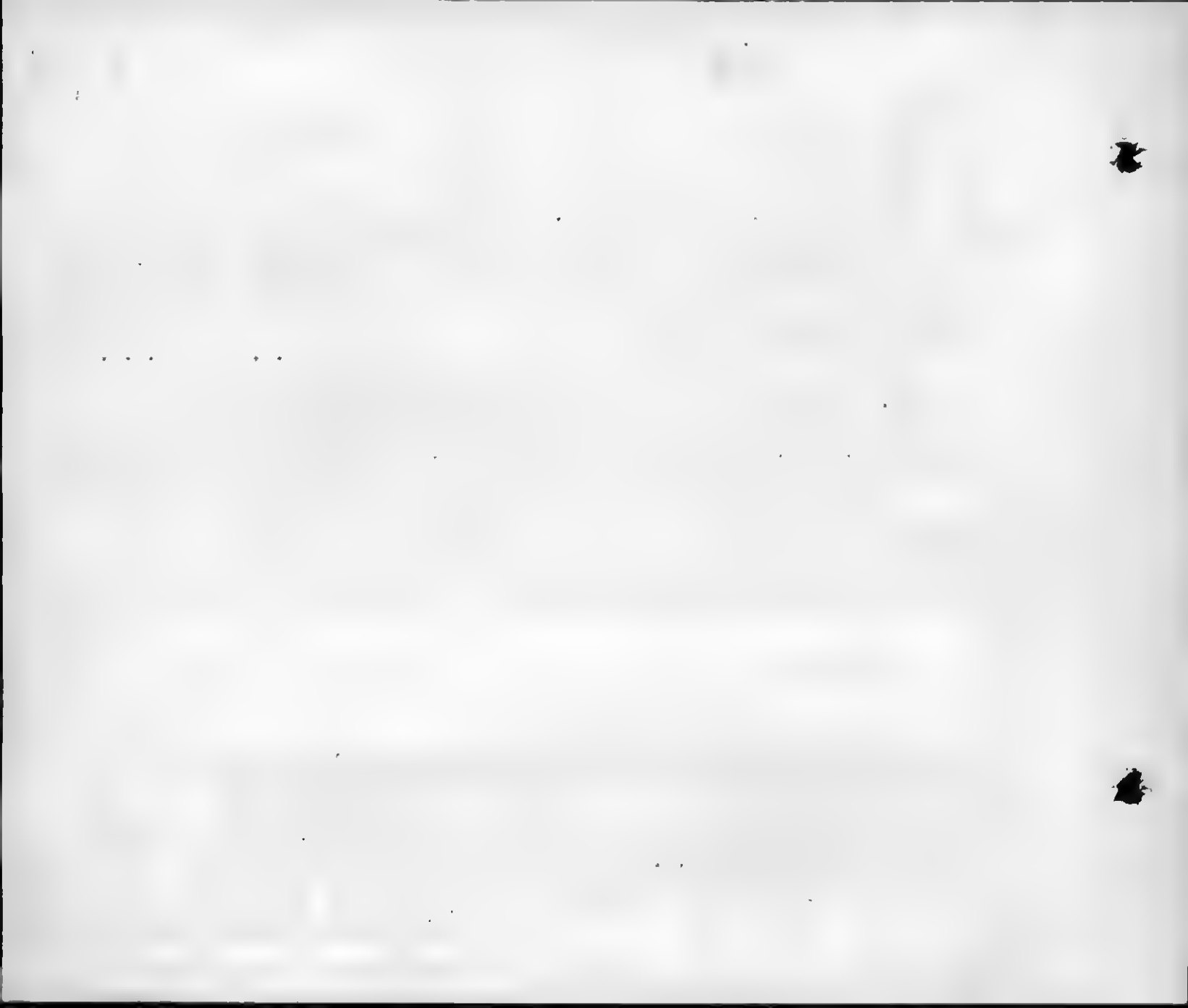
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5856 CERTIFICATE OF DEATH

Reg. Dist. No.

05847

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>37 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Herndon</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>Route #3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sharon</b> Middle <b>Marie</b> Last <b>Thorpe</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1954</b>		9. AGE (In years last birthday) <b>4 yrs</b>	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herman O. Thorpe</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Holdaway</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE LYMPHOCYTIC LEUKEMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>6 1/2 MRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 31, 19 59</b> to <b>May 7, 19 59</b> , that I last saw the deceased alive on <b>May 7, 19 59</b> , and that death occurred at <b>9:15a M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. Richard Lee</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5/7/59</b>			
PHYSICIAN'S NAME (Type) <b>G. RICHARD LEE, M.D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Removal - Burial</b>		<b>May 10, 19 59</b>		<b>Chestnut Grove Cemetery</b>		<b>Herndon, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Berkeley Green</b>				ADDRESS <b>Herndon, Va.</b>		24a. REC'D BY REGISTRAR <b>MAY 12 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinn</b>	





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

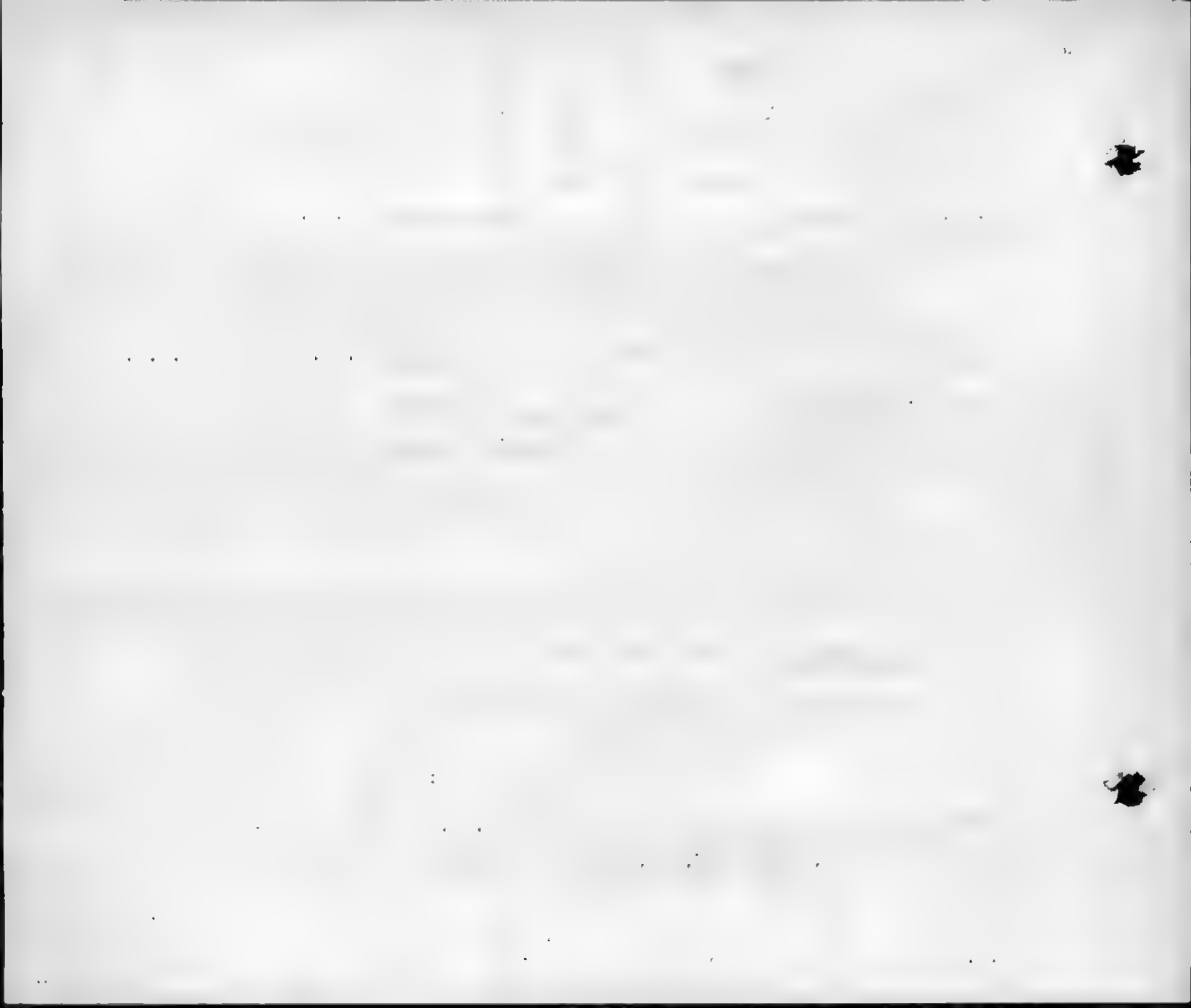
05848

Reg. Dist. No. 215

5857

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>36 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X E</b> d. STREET ADDRESS <b>300 T Street, N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Vernon Lawson UPDEGROVE</b>		4. DATE OF DEATH Month Day Year <b>May 9 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-8-17</b>
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months Days Hours Mins	IF UNDER 24 HRS Months Days Hours Mins
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank E. UPDEGROVE</b>		14. MOTHER'S MAIDEN NAME <b>Hazel SENNE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes 1940-1945</b>		16. SOCIAL SECURITY NO. <b>1940-1945</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Carcinomatous</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma, Pancreas</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>18 mos</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 3 19 59</b> , to <b>May 9 19 59</b> , that I last saw the deceased alive on <b>May 8 19 59</b> , and that death occurred at <b>3:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Troy</b>		ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b>	
PHYSICIAN'S NAME (Type) <b>John W. TROY, CDR, MC, USN</b>		DATE SIGNED <b>5-9-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-13-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 12 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Its 7-11-59 et

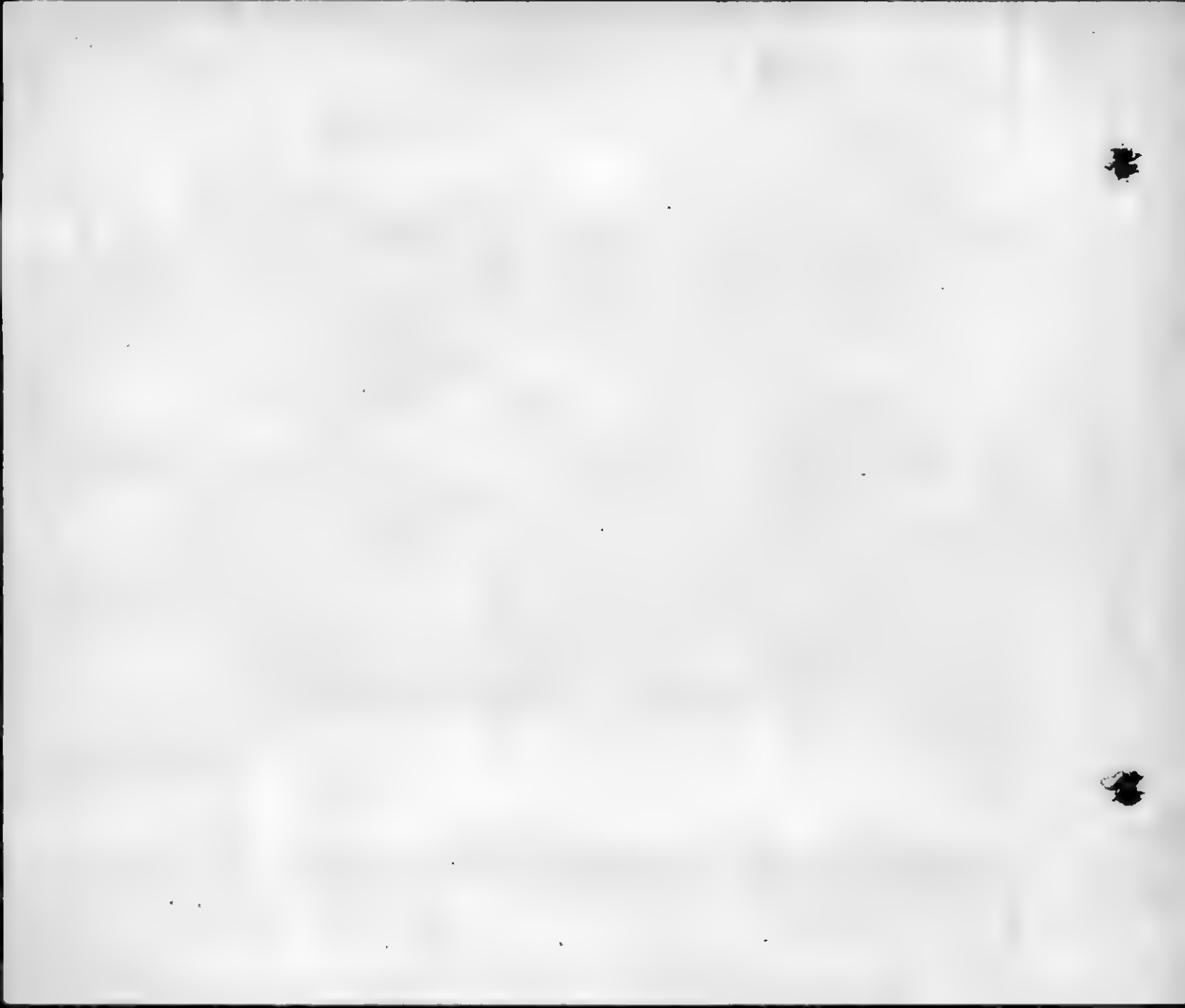
## CERTIFICATE OF DEATH

05849

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8911 1/2 - Montgomery Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Herbert E. Wade</u>		<b>4. DATE OF DEATH</b> Month <u>5</u> - Day <u>1</u> - Year <u>1959</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Jan 20 1884</u>	<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>	
<b>13. FATHER'S NAME</b> <u>Thomas J Wade</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. Phillips</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		<b>16. SOCIAL SECURITY NO.</b> <u>225-05-4815</u> <b>17. INFORMANT</b> <u>Mrs Franklin Beavers - same as above</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive heart failure</u> DUE TO (b) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. _____ DUE TO (c) _____			<b>INTERVAL BETWEEN ONSET AND DEATH</b>  
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
<b>20c. TIME OF INJURY</b> Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year <u>1959</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  	<b>20f. (City or town)</b> _____ (County) _____ (State) _____
<b>21. I certify that I attended the deceased from</b> <u>4/18/59</u> <b>19</b> <u>5/1</u> <b>1959</b> , that I last saw the deceased alive on <u>5/1</u> <b>1959</b> , and that death occurred at <u>1227</u> <b>M.</b> , from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <u>8805 Conn Ave</u> <b>DATE SIGNED</b> <u>5/1/59</u>			
<b>ACTUAL SIGNATURE</b> <u>John B. Umhoeu</u> <b>M.D.</b>		<b>PHYSICIAN'S NAME (Type)</b> <u>John B. Umhoeu</u> <u>Chevy Chase 16 Md.</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>5-4-59</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt Olivet</u>	<b>22d. LOCATION</b> (City, town, or county) _____ (State) _____ <u>Washington D.C.</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lee Funeral Home - Washington D.C.</u>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>MAY 6 '59</u>	<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05850

5859

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roberta</u> Middle <u>Lee</u> Last <u>Wandling</u>		4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 3 XXXXX 1871</u>
9. AGE (In years last birthday) <u>88</u> yrs		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	11. IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Admission</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13. FATHER'S NAME <u>JOHN WANDLING</u>		14. MOTHER'S MAIDEN NAME <u>JANE EVANS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Eliz Smith</u>		Address <u>3605 Dupont Ave.</u> <u>Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adenocarcinoma of Uterus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>Apr 11</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Apr</u> , 19 <u>55</u> , to <u>May 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>59</u> , and that death occurred at <u>12:36 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>John Lawrence Avery</u> M.D. <u>10110 Georgia Ave</u> <u>5/4/59</u> PHYSICIAN'S NAME (Type) <u>John Lawrence Avery</u> <u>Silver Spring, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		22b. DATE THEREOF <u>5/6/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ELMWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>OWENSBORO, KENTUCKY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond G. Zinke</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>MAY 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05851

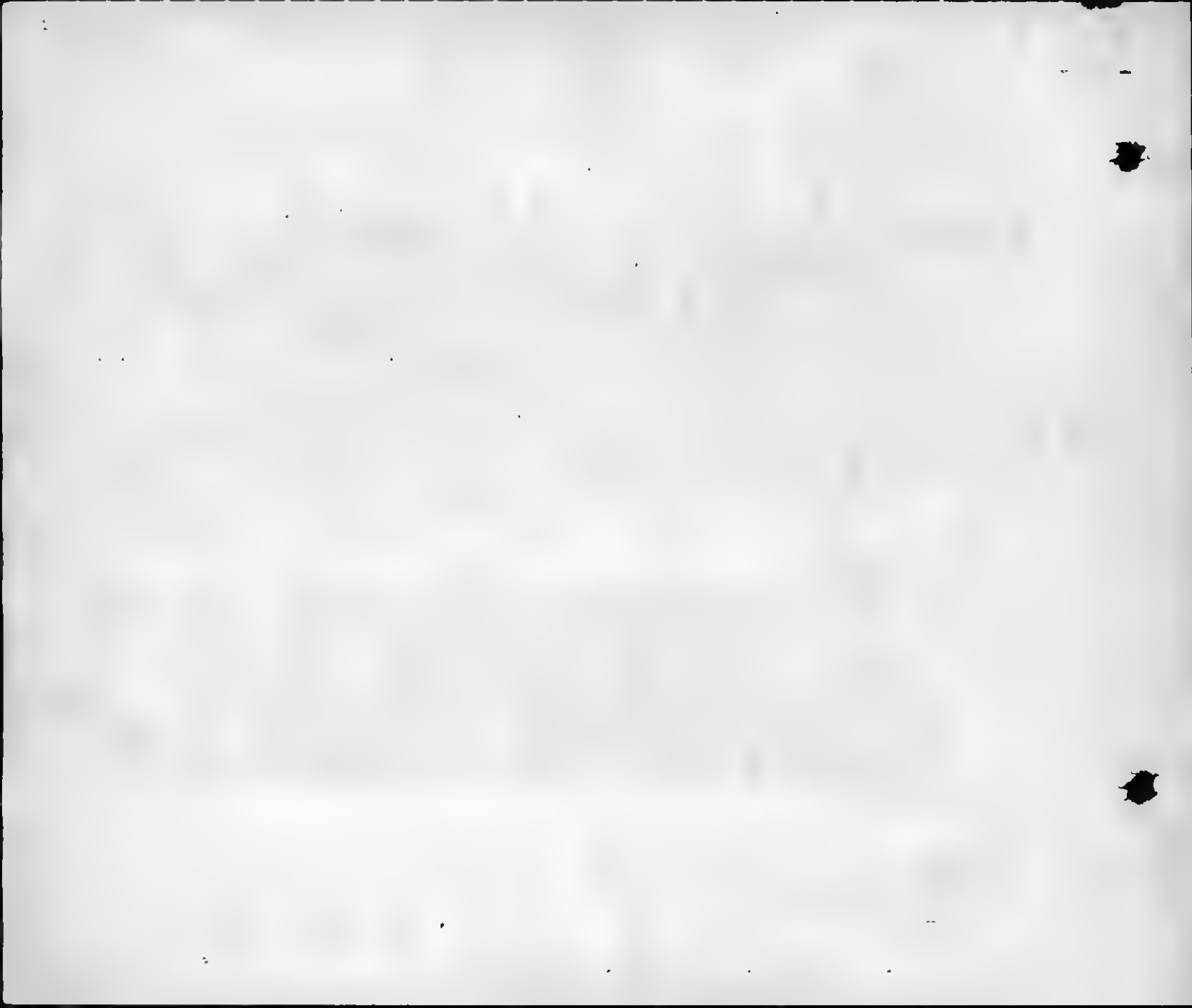
Reg. Dist. No.

5860

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Conn.</b> b. COUNTY <b>New Haven</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Meriden</b> <i>45 X 3</i>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>				d. STREET ADDRESS <b>560 New Hanover Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Everett</b> Middle <b>A.</b> Last <b>Ward</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1899</b>	9. AGE (In years last birthday) <b>59 yrs.</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>21</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machinist</b>		11. BIRTHPLACE (State or foreign country) <b>Conn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Fredrick Ward</b>				14. MOTHER'S MAIDEN NAME <b>(unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>042-14-7768</b>		17. INFORMANT <b>Son in Law (Robert Roosa)</b>		Address <b>4210 South End Rd. Rockville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs</b> <b>?</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschert</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHE</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Trans</b>		22b. DATE THEREOF <b>5/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Walnut Grove Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Meriden, Connecticut</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAY 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## CERTIFICATE OF DEATH

Reg. Dist. No.

5861

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital Piny Meeting House Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSE GARNETT</u> Middle <u>WARD</u> Last <u>WARD</u>		4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10 1882</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>20</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harrison Ward</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Thrift</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217036-6714</u>	
17. INFORMANT <u>Orida J. Ward</u>		Address <u>Same Wife.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>526X</u> DUE TO <u>Chronic pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic pneumonia</u> (c) <u>Chronic pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 days</u> <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>juvenile carcinoma</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1, 1957</u> to <u>5/30/59</u> , that I last saw the deceased alive on <u>5/30/59</u> , and that death occurred at <u>home</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen N. Jones</u>		DATE SIGNED <u>5/30/59</u>	
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>		ADDRESS <u>Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Darnestown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**INSTRUCTIONS**

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8 FilmG2+3 6-2-59 et

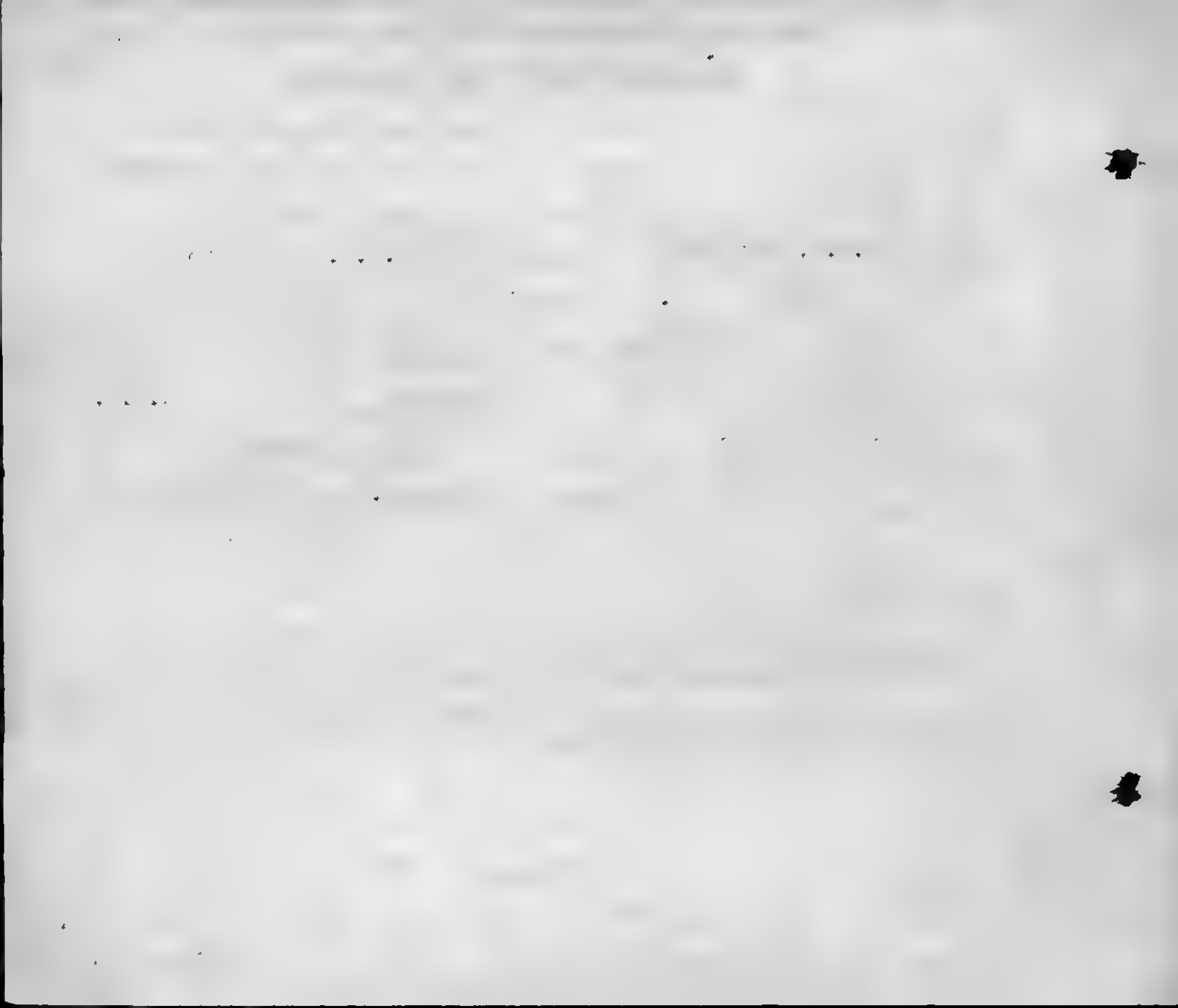
## CERTIFICATE OF DEATH

05853

5862

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Montgomery</b>		STATE <b>MARYLAND</b>		STATE <b>Maryland</b>		COUNTY <b>Montgomery</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cedar Grove</b>		LENGTH OF STAY (in this place) <b>80 Years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cedar Grove</b>		TOWN <b>Cedar Grove</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>R.F.D. Germantown</b>				STREET ADDRESS (If rural give location) <b>R.F.D. Germantown</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Vertie A. Watkins</b>				<b>4. DATE OF DEATH</b> (Month) <b>May</b> (Day) <b>22</b> (Year) <b>1959</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>July 27 1873</b>	<b>9. AGE last birthday</b> <b>85 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13. FATHER'S NAME</b> <b>William Mullinix</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Bowman</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mable A. Tregoning Same As 2</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>IMMEDIATE CAUSE (A)</b> <b>interiosclerotic cardiovascular disease</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>10 years</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST, DUE TO</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 3/10, 1948, to 5/17, 1959, that I last saw the deceased alive on 5/22, 1959, and that death occurred at 2:00 p.m. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>James P. Kover</b>				<b>DATE SIGNED</b> <b>5/23/59</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>May 25 59</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Salem Methodist</b>	
<b>24. REC'D BY REGISTRAR</b>				<b>REGISTRAR'S SIGNATURE</b> <b>Clara L. Kover</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Ray W. Barber - Laytonville, Md</b>	
<b>DATE</b> <b>MAY 27 '59</b>		<b>ADDRESS (Street, city, town, state)</b> <b>Cedar Grove Md.</b>					



## CERTIFICATE OF DEATH

Reg. Dist. No.

05854

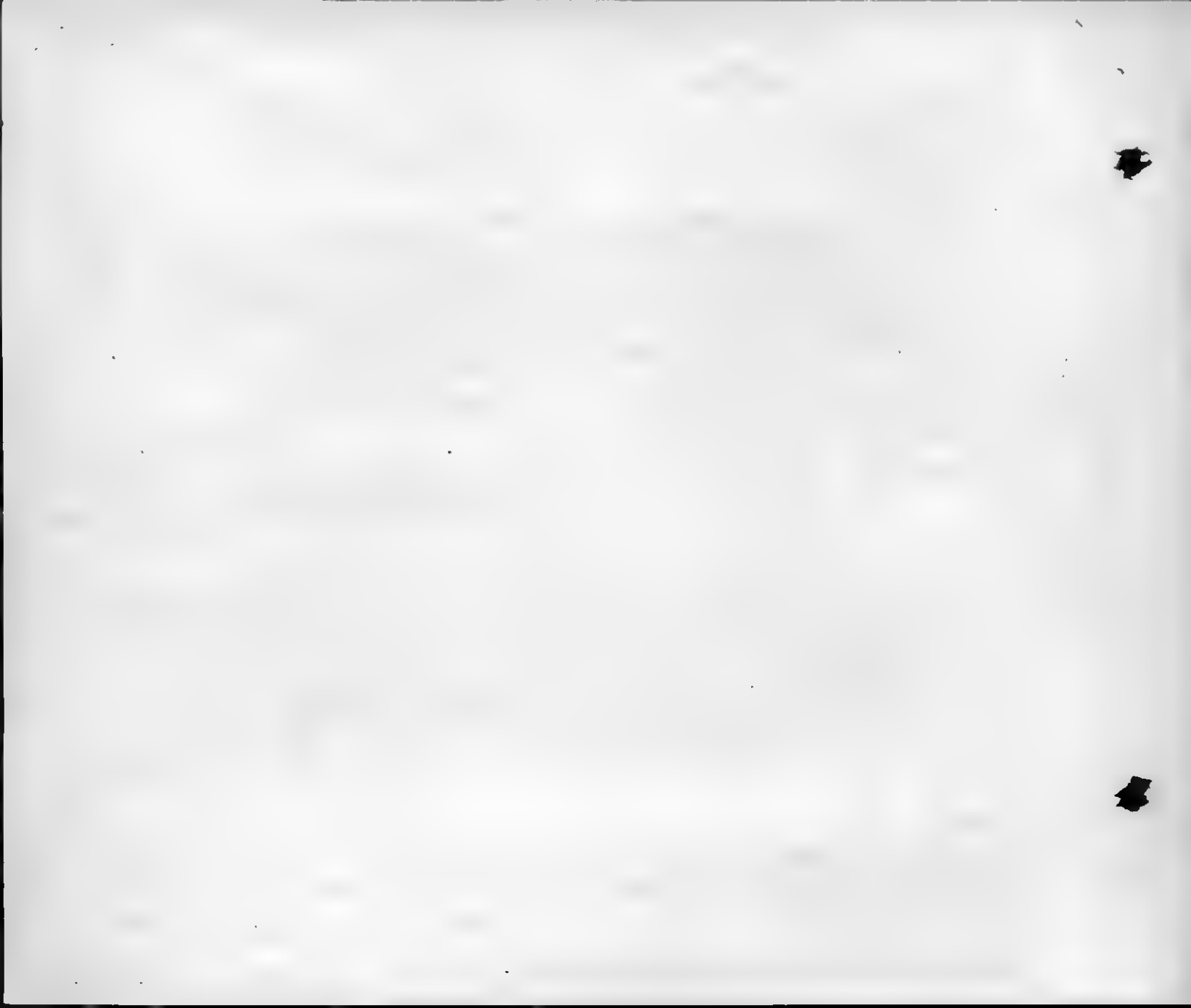
5863

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) STATE <b>Maryland</b> COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Hunting Hill</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GRACE B. WHALEN</b>		4. DATE OF DEATH Month <b>May</b> 17, Day <b>17</b> , Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1877</b>
9. AGE (In years last birthday) <b>82</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hamilton Crown</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Allen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>	
17. INFORMANT <b>William M. Whalen-Rockville, Md.-Son</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage of right frontal lobe, with metastasis to liver &amp; lungs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 years.</b>	
DUE TO (b) <b>(This patient refused surgery)</b>			
DUE TO (c) <b>(This patient refused surgery)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity &amp; Hypertension - 5 years.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>17</b> (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> , 19... to <b>May 17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 17</b> , 19 <b>59</b> , and that death occurred at <b>14</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William A. Linthicum</b> M.D.		DATE SIGNED <b>5/18/59</b>	
PHYSICIAN'S NAME (Type) <b>William A. Linthicum</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-20-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 19 59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered to the registrar for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5864

## CERTIFICATE OF DEATH

05855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>3913 Ingomar St N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Beulah</b> First Middle Last <b>Whitaker</b>		4. DATE OF DEATH Month Day Year <b>May 18 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1868</b>
9. AGE (In years last birthday) <b>90</b> yrs		IF UNDER 1 YEAR Months Days Hours Min <b>10</b> <b>15</b> <b>45</b> <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tenn.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Al. Whitaker</b>		14. MOTHER'S MAIDEN NAME <b>Hester Trundle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>No</b>	
17. INFORMANT <b>Mrs Samuel Huey-3913-Ingomar St. N.W.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b> <b>4.20.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease, advanced</b> (c) <b>Arteriosclerosis, general advanced</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>3 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1953</b> to <b>May 16, 1959</b> , that I last saw the deceased alive on <b>5/12/1959</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3921 Ingomar St N.W. Wash D.C.</b> DATE SIGNED <b>5/16/59</b>			
ACTUAL SIGNATURE <b>Stewart Clapp</b>		M.D. <b>3921 Ingomar St N.W. Wash D.C.</b>	
PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>		<b>Wash D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 19, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Monacacy</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>		ADDRESS <b>Washington, D.C.</b>	
24a. REC'D BY REGISTRAR <b>MAY 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	





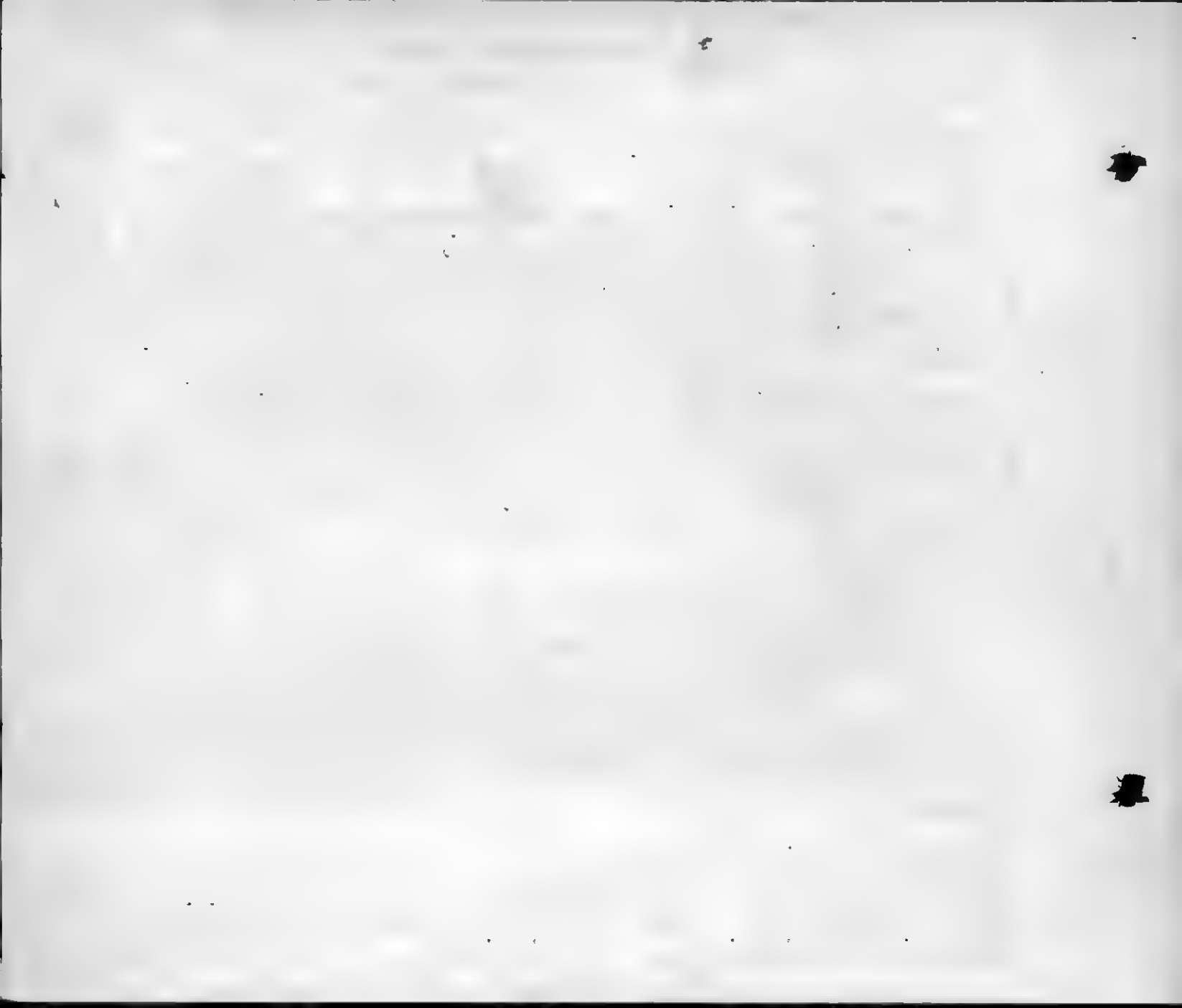
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b. <u>3 wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>41st</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash San &amp; Hosp</u>				d. STREET ADDRESS <u>7914 13th St N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William W. HASE</u>				4. DATE OF DEATH Month <u>5</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-24-82</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levine &amp; Schenck</u>				14. MOTHER'S MAIDEN NAME <u>Mary XXXXXXX Moerder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Hosp Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from ruptured aortic aneurysm</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertension</u> DUE TO <u>arteriosclerosis, aortic atherosclerosis</u> (c) <u>adrenocortical insufficiency, metastatic cancer</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>2 1/2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 July</u> , 19 <u>58</u> , to <u>14 May</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>13 May</u> , 19 <u>59</u> , and that death occurred at <u>1:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Samuel T. Kimble</u>				M.D. <u>929 Parkview Ave. S.E. 14 May '59</u>			
PHYSICIAN'S NAME (Type) <u>SERUCH T. KIMBLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5/16/59</u>		<u>ROCK CREEK CEMETERY</u>		<u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5725 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hosp.</u>				e. STREET ADDRESS <u>8119 Flower Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thornton Macpherson Woodall</u>				4. DATE OF DEATH Month Day Year <u>5 / 18 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/8/91</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plastering Contractor - self</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>employed</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>Thomas J. Woodall</u>				14. MOTHER'S MAIDEN NAME <u>Louella Wedding</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>WW. I</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Pf's Hosp. Record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> <u>420.0</u> DUE TO <u>Atherosclerotic hypertensive heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>4 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1958</u> , 19 <u>58</u> , to <u>5/18/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/17/59</u> , 19 <u>59</u> , and that death occurred at <u>7:35 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard J. Walsh</u> M.D.				ADDRESS (Street, city or town, state) <u>900-17th St. S.W. 5/18/59</u>			
PHYSICIAN'S NAME (Type) <u>Bernard J. Walsh</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 20 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mausoleum</u>		22d. LOCATION (City, town, or county) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Canal St. N.W.</u>				24a. REC'D BY REGISTRAR <u>MAY 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orly &amp; Anna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5865 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>			c. LENGTH OF STAY IN 1b <b>1/2 hr.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WALLIS</b> Middle <b>C</b> Last <b>WRIGHT</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>13</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 30, 1898</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INTER'L REPRESENTATIVE ELEC. WORKERS</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>INTER'L BRO. HOOD</b>		11. BIRTHPLACE (State or foreign country) <b>HULL, ENGLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>FRANCIS WRIGHT</b>		
14. MOTHER'S MAIDEN NAME <b>CHARLOTTE WALLIS</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>1917-1919</b>		
16. SOCIAL SECURITY NO. <b>INFORMANT</b>			Address <b>MARTHA L. WRIGHT (Wife) AS ABOVE</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>3 years</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 HOURS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>8-2</b> , 1958, to <b>5-13</b> , 1959, that I last saw the deceased alive on <b>5-13</b> , 1959, and that death occurred at <b>6:35</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Washington Clinic, D.C.</b> DATE SIGNED <b>Philip R. James</b>					
ACTUAL SIGNATURE <b>Philip R. James</b>		PHYSICIAN'S NAME (Type) <b>Philip R. James</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>5/16/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Logan Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Logan, Utah</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.</b>			24a. REC'D BY REGISTRAR <b>MAY 14 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>	

MEDICAL CERTIFICATION

Page 4

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

The first of these is the fact that the  
 system is not a simple one. It is a  
 complex one, and it is not possible to  
 describe it in a few words. It is a  
 system of many parts, and it is not  
 possible to describe it in a few words.

The second of these is the fact that the  
 system is not a simple one. It is a  
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